mcgill daily

VOL. 63 NO. 98 TUESDAY, MARCH 19,1974 3 CENTS

Hsieh talks on return to Chinese birthplace

by Edward Liu

Using slides and a vivid set of memories, Professor Hsieh Pei-chih last night chronicled the tremendous strides made in the Chinese countryside since 1949.

Speaking to about 80 people in the Union ballroom, Hsieh focused on his childhood home Linching county and Shangtung in Northern China. Hsieh's family fled from China at the time of liberation (1949), but Hsieh has since returned in 1972 and 1973 for visits.

From the two visits, Hsieh concluded that "in my villages and many other villages, every family ...has benefited from the Chinese revolution."

Hsieh told the history of his village prior to Liberation — the poverty, famines, and exploitation by landlords. Aggravating this, he said, was peasant superstition, which continually shackled the peasants to a life of misery. But the spirit of exuberance and self-reliance brought by the revolution has replaced the complacency and exploitation of the past, he said.

Hsieh berated the distortion of many North American reports about China that use "the concentration camp" image from the 50's. He also criticized a recent documentary about Shanghai which he said, "tends to portray the least favourable and most prejudicial aspects of China's largest industrial city." He accused the program's producers of completely omitting the great industrial achievements of the Chinese people in the city.

Professor Hsieh Pei-chih speaking last night on the remarkable strides China has made since 1949.

Hsieh said he was impressed by the infusion of women and youth in leadership positions on the local level. Touching on intellectual youth, Hsieh said their return to the Chinese countryside will help to "bridge the gap between cities and rural areas for years to come."

"Unlike the past," Hsieh said, "the Chinese people today are not worried about their future. Famines, floods and feudalism have been given a good licking."

Junta opponent to speak here

by H. Blanco

A former Swedish ambassador to Chile, who was expelled from the country last December for aiding victims of the military junta's repression, is speaking at McGill tonight.

Harald Edelstam, 61, intervened on behalf of many people arrested by the Chilean government for political reasons, and also prevented Chilean troops from storming the Cuban embassy where about 20 political refugees were seeking asylum after the Cuban ambassador and his staff were expelled from the country.

For these and other acts the Chilean junta accused him of exceeding his diplomatic duties and ordered him to leave the country.

A career diplomat, Edelstam was expelled from his post as Swedish ambassador to Norway during the Nazi occupation there in 1944 for his assistance to Norwegians seeking asylum.

He is speaking tonight at 8 p.m. in the Union ballroom.

Management student fights laundry rip-off

by Jan Van Eck

The following is the true saga of how Jan Van Eck, Management U-2, single-handedly took on the Coin-a-matic washing machine monopoly in the Student Union.

Down in the bowels of the Student Union building exists a washing machine, rented by past executives of the Students' Society so that we can all walk around with clean shirts and socks; herewith the tale of what happened to one whose clothes got ripped - literally.

coinamatic caper

Several years ago, with the destruction of the local laundromats in the student ghetto area in the demolition for the Concordia project, the executive of the Students' Society decided to install a washer-dryer combination so that students wouldn't have to wash their clothes in the sink. Instead of disbursing Society funds and owning the machines, they elected to allow a private entrepreneur Coin-a-matic Inc., to install two machines and charge users a quarter a shot. But what happens if the machine is defective and your clothing gets ripped up? While legally they have absolute liability, trying to collect is an entirely different matter. I tried, and here's what happened.

On April 10th, 1973 (this case goes back a while!), I dumped my usual load of shirts and socks into the machine and fired in a quarter. Everything went fine until the "spin" cycle, when the clothes crept up the side of the washtub and disappeared over the edge. Somewhat disconcerted in trying to retrieve a shirt with the sleeve detached, I peered into the machine and lo! there was no clothes guard! The sleeve, plus socks and the like, were now somewhere in the depths of the machinery.

A call to Coin-a-matic brought duplicate claim forms in the mail.

Hardly satisfied, on June 13th I fired off another letter, indicating that either they paid up or they would be hauled into court. By attaching a copy of the prepared action, it apparently dawned on them that I was not about to forget the matter. The response? A Duly filled in and returned with a bill for $20.62, I waited for a cheque. Nothing happened.

A month later, a follow-up call: "But Mr. Van Eck, we sent you a letter with some free tokens! It must have gotten lost in the mail!" I replied that I was not in the least interested in their tokens, since I had no intention of using their machine in the future, and how about a cheque instead? So I got a registered letter saying how nice they wanted to be to me, and a cheque for $12.00. The theory here is absurdly blatant - crassly buy the complainer off with a partial payment, and for $8.62 he won't pursue the matter.

But I cannot be bought. There is no way that I was about to let them get away with this maneuver, and in the latest demand letter, I indicated that, among other things, the only way to hit the washing-machine monopoly where it hurts is to go after their money mills - the machines themselves. That is, either they pay up, or I make representations to the officers of the Students' Society to have their machines thrown out of the Union.

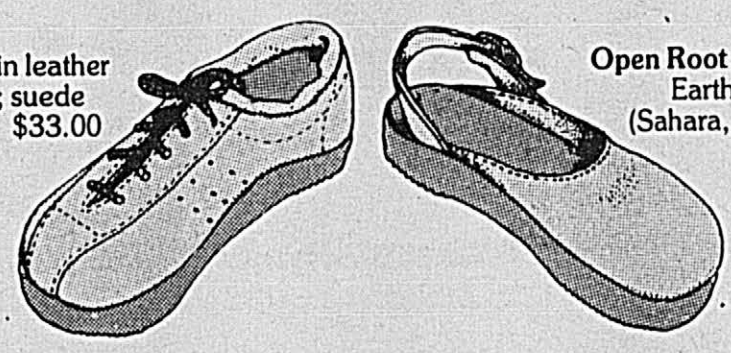
Coin-a-matic's reply, indicates the true nature of the beast - behind the polite smiles and the clammy handshake, the spiked club. To quote verbatim from the letter from their attorneys:

"We are instructed to notify you that your proposed activities mentioned in your said letter constitute a violation of law and unless we receive a letter of retraction of your alleged intent, we are instructed to take proceedings by way of an INJUNCTION against you without any further notice or delay."

As of today, we are at a Mexican stand-off. I haven't heard from the bailiff, and they haven't heard from me. As far as I am concerned, the bill for $9.45 still stands, and quite obviously they have absolutely no intention of honouring their obligations. Aside from the absurdity of the legal position of obtaining an injunction, it does however indicate to what extremes Coin-a-matic will go to avoid payments of claims made by their customers. In the final analysis this is the issue: when you put in your quarter, you do it entirely at your own risk.

Turn to page four for a look at the letters written by Van Eck and Coinamatic's replies.

You don't blow an extraordinary idea on an ordinary shoe.



Sport Root in leather (New Earth); suede (Sahara) $33.00

Open Root in leather (New Earth, White); suede (Sahara, Blue) $23.50

By now you're probably aware that Roots are not like other kinds of footwear. The heel is lower to give you the natural kind of walk you'd get by going barefoot in sand. The arch is supported, so if you spend much time on your feet you'll now spend it in much greater comfort. The rocker sole helps spring you off on each footstep, so walking becomes a little less work than it ever was before.

But a big part of Roots' success lies in not *how* they're made, but *how well*. Only the finest grade Canadian hides are selected. These are hand-crafted into Roots, simply because, for much of our production, the most efficient machine is still the human hand.

This is why, of all the reasons we could give you for trying Roots, none would fit quite so well as the shoe itself.

roots
NATURAL FOOTWEAR™

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(at de Maisonneuve)

Swim Director

For Children's country day camp

for info call Green Acres Day Camp
488-9148

BENY AFLALO

The Israel Aliyah office will answer all questions concerning ALIYAH
March 19 1-3 o'clock
3460 Stanley St. HILLEL

NOTICE

The McGill Daily will be published every day until March 20.

THE LAST SPECIAL ISSUE is coming out March 26

It is advisable to reserve space as far in advance as possible.
The DEADLINE for the March 26 issue will be Friday, March 22 at 5 o'clock.

ad office

Malaysian Singapore Students' Association
PRESENTS
Professor GUTKIND
Dept. of Anthropology, McGill
Speaking on:
URBANIZATION AND DEVELOPMENT PROBLEMS IN THE THIRD WORLD
Time: 7:00 p.m. Union 327 Tues. March 19th

TYPING

Experienced in typing dissertations and term papers. Brand new electric typewriter (Olympia Report). Diacritical marks for transliterating Arabic, Persian, Urdu, Turkish, French, and German languages on the typewriter. Reasonable rates.

Call Aishah Ardur Rabb at 656-0402.
Material could be collected from and delivered at McGill at appointed times.

STUDENTS

If you wish to spend the first two nights of Passover with a family.
Call HILLEL 845-9171.

Summer Staff Openings

WATERFRONT DIRECTOR
Min age 21 Salary to $1100
SR. MALE COUNSELLORS
Min age 19 Salary to $775
ARTS & CRAFTS SUPERVISOR
KITCHEN HELPERS

Apply:
Jewish Community Camps
5151 Cote St. Catherine Rd., Rm. 203
Montreal, Que. Tel: 735-3669

International Festival

Cultural Evening

Thursday, March 21

at Douglas Hall,
3851 University St,
at 8 pm; 50 cents

Songs and dances from the Caribbean, China, Japan, Latin America, India, Malaysia & Indonesia.

Films and Discussions

Friday, March 22

Theme.
Third World—Dependence and Development

Afternoon session
12-4 pm
Leacock 219
Speakers:
Prof. Feroz Ahmad
editor **Pakistan Forum**
Sociology professor,

Prof. Julio Treslerra
Peruvian citizen
Sociology professor,

Films:
"Third World Unity"
"Mozambique: A Luta Continuada"
"In African Hands"

Evening Session
8 pm
Leacock 219
Speaker:
His Excellency, F. Rutakyamirwa, the High Commissioner of the United Republic of Tanzania to Canada
"Social Change in Tanzania"

Dinner & Dance

Saturday, March 23

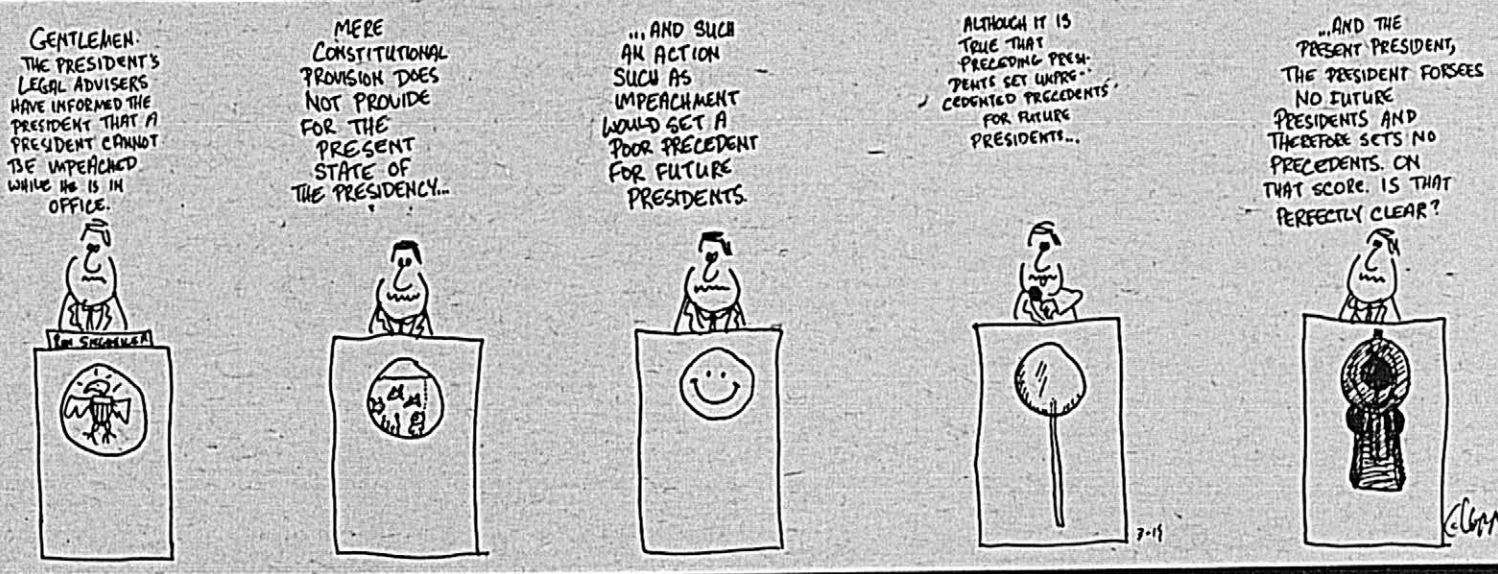
Dinner
8 pm
Union 2nd floor
$2.00
Dance featuring Steel band:
The Trinidad Melotones
10:30 pm
Union Ballroom
$1.50

Both Dinner and Dance:
$3.00

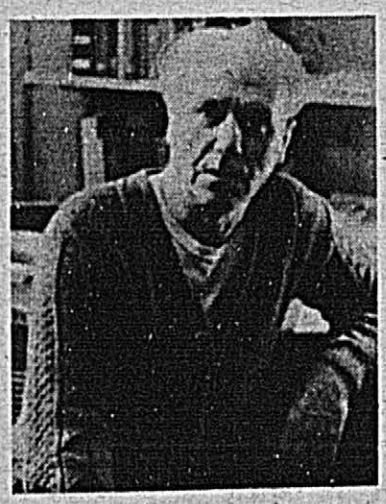
Tickets will be sold starting Monday, March 18 in the ISA office (B40 Union) from 10-4, in the Union lobby from 12-2 and at the door.

Sponsored by the ISA

LEAN AND HUNGRY/BY GEORGE KOPP



Sweat and Struggle: real working class history



Jack Scott: worker, union activist, Communist Party member for three decades, founder of the Progressive Workers' Movement, and author of "Sweat and Struggle."

Sweat and Struggle: Working Class Struggles in Canada. Vol. 1, 1789-1899
by Jack Scott
New Star Books. $2.00

by Andrew Phillips

If anyone is in a position to start the formidable task of recording the still-unwritten history of the Canadian working class, it is Jack Scott. As a worker and union activist all his 63 years, Scott knows what he's talking about; as a revolutionary he has the insight and dedication necessary to rise above academic detachment to committed involvement.

The kind of history Jack Scott writes isn't found in high school or university textbooks, where, we are told, history is an account of the deeds of famous men who "make history" and determine humanity's fate. Neither is it found in standard "labour history"—where faceless union structures act as the heroes and attention is focused on organizational achievement divorced from day-to-day struggle. Scott, instead, writes about ordinary people—their exploitation and oppression and their resistance to it.

In the introduction to this, his first book, he points out that few contemporary scholars will go so far as to openly dismiss the role of working people in shaping history, but

...the more sophisticated approach of ignoring the role and contribution, and even the very presence of working people in the building and shaping of the nation, can be more effective than pronouncing vile slanders against their human dignity, and social and economic worth, which must at least take cognizance of the existence of working people.

With this as the dominant trend among Canadian historians, Scott's efforts are a very welcome beginning to the discovery of the history of the majority of the people in this country. Canada has a small but growing tradition of radical historiography—in which names like Gustavus Myers and Stanley Ryerson stand out—but Scott's book is practically the first to deal specifically with working class struggles. Myers, Ryerson, and others began a class analysis of Canadian history but, like the mainstream historians, focused primarily on the deeds of the "great men"—even if they did show them up as ruthless merchants, corrupt politicians, and bloated monopolists.

Scott's work takes as its starting point the activities of ordinary working people resisting the attempts of these great men to build empires on their backs—or as he puts it, out of "ruthless exploitation, outright theft, corruption, and the spilling of rivers of blood." Unions naturally play a major role in such an analysis, but they do not eclipse people's achievements and sacrifices. Scott puts it this way:

Organization grew out of struggle, not the contrary...The aim is to set the act of struggle in the forefront and to present organization in its proper place—secondary and subservient to the struggle, an improvised vehicle used in the preliminary skirmishes with capital along the road to a better world.

Sweat and Struggle focuses on these struggles—from that of eighteenth century voyageurs against exploitation by the Hudson's Bay Company, to Montreal workers supporting the Patriotes in the 1837 Rebellion, to the bitter conflicts between British Columbia miners and their bosses. What the record of these fights shows most clearly is that the rights won over the years by the organized labor movement have been literally wrenched from those who control the economy and the country.

Today the most blatant anti-union tactics have been declared illegal, but Scott's work shows that the companies and the government didn't hesitate in the past to use everying from intimidation of organizers to private police forces to stop their employees' efforts to win basic rights on the job. It is impossible to understand the nature of present employer—employee conflicts without some idea of this historical background, for while the forms of the struggle have changed, the basic social contradictions which produce it remain.

Essential reading

Scott's book has a lot of information that isn't available anywhere else and so is essential reading for anyone interested in working class history. It suffers, however, from a lack of real analysis linking one struggle to the next, and placing each in the total context of economic development and political debate. The book leaves a rather disconnected impression of the development of the workers' movement, and would be very hard to understand without a basic knowledge of general Canadian history. Particularly weak is Scott's conclusion— that a century's struggles taught the workers which side the state is really on, and the necessity for taking the fight into the political arena. True, but not very profound.

Scott is now working on the second volume of his work, continuing the record up to the present day. Hopefully the second book, while including as much detail and new information as the first, will also include a more thorough and developed analysis of Canadian working class struggles and give some perspectives for the future.

Phooey on Kung Fu!

by Edward Liu

Hollywood is ushering in a new wave of films about Asians, both on TV and in the movie theatres. David Carradine, or Kung Fu, is the hero of the new American generation. Every Monday and Thursday night, this "adhesive-Asian" mumbles his way with supposed "words of wisdom" through the TV tubes of Montreal.

The "Kung Fu" themes are repetitious. Kung Fu, a self-avowed ex-Buddhist monk, always gets into trouble...spreads his trite "pacifistic" words of wisdom...chops and kicks the evil forces to a pulp...and in a grand finale, exits leaving the audience ecstatic and gulping.

Behind this TV "smath", there is a controversial history of Asian-American protests. When the star role was up for casting, there were several Asian actors brushed aside to make way for David Carradine and his adhesive tapes, supposedly because the Asians lacked charisma and "star appeal". To circumvent public protests from the Chines-American community of California, the producers rewrote the script revising the adventures of a 100 per cent Chinese monk to a half-breed Caine.

This genre of film is objectionable in that it forms the North-American image and perception of Asians and the history of Asian immigrants in the New World. The "Kung Fu" period is supposed to be the frontier days in the American West. As a matter of history, the Asian immigrants were then the objects of tremendous prejudices, discrimination, and abuse.

Even in Caine's hypothetical situation, he would have been butchered in straying away from the Chinese ghettos set up for the coolie-labour chain gangs building the trans-continental railway. It is important to note that the American Chinese Exclusion Act of 1882 was the culmination of a series of Chinese massacres by the frontiersmen bred on hatred, racism, and fears of competition. The annals of the California archives will confirm these hidden aspects of history.

Asia is more than egg rolls, Confucius, and Suzie Wong. Today, the real Asia is in the midst of a tremendous turbulence whereby its majority, the teeming masses of peasantry, are rising up to break their feudal and colonial yokes. Outside of the highly westernized urban centres like Hong Kong, Taipei, and Calcutta, history is being shaped in the countryside! For us, ten thousand miles away, it is necessaryto try to understand the trends instead of gullibly swallowing the cultural poison of the genre of "Kung Fu."

The Van Eck-Coinamatic correspondence

CLAIM FOR DAMAGED CLOTHING April 11, 1973

This claim is to be made in duplicate and returned to COINAMATIC within 7 days of occurence by the person whose clothes were damaged.

ITEM	QUANTITY	DESCRIPTION	NEW VALUE	DATE ARTICLE BOUGHT	CLAIM VALUE
1	2	Shirt, Men's	$8.50 ea.	oo	$17.00
2	1	Sock, Men's	$2.00	oo	$2.00
3	1	Tax, Provincial, 8%	oo	oo	$1.52
4	1	Stamp, Federal	$3.00	oo	$0.06
5	1	Envelope, plain	$0.02	oo	$0.02
		Surcharge			$0.62

Attach additional articles to this list. Minor damage to 3rd shirt not being claimed

Describe the type of damage. Swallowing of clothing by machine.

Describe the reason you think the machine was at fault or how the damage occured. Lack of proper clothes guard to prevent items being sucked down the overflow.

Phase #1: Van Eck sends in his claims for $20 worth of damage.

Mr. Jan van Eck, April 26, 1973
3653 University St.,
Montreal 112, Que.

Re Your claim received April 17th 1973.

Dear Sir:

We acknowledge receipt of your claim as listed above, which has been given our careful consideration.

Immediately following your complaint, we thoroughly checked our equipment in your building, and found it in good running order.

You will understand that ours is a "Self-service" facility wherein the user is the only one who controls the loading and unloading of the machine as well as the content of the laundry load, which, in itself, could be the cause of damage.

Although we do appreciate your patronage, we regretfully have to decline responsibility for this claim.

However, as a gesture of good-will, we are sending you herewith enclose twelve (12) tokens for free washes in our equipment.

Please use these tokens with the same assurance that thousands of people do, each day, year in and year out, when they launder the clean, economical Coinamatic way.

Very truly yours,
COINAMATIC INC.

Phase #2: Coin-a-matic refuses the claim but offers Van Eck 12 free washes instead.

Office of the General Manager March 1, 1974
Coinamatic Inc.
8480 Darnley Road
Montreal 307, Quebec

Gentlemen:

With reference to the episode of April 10, 1973, in which my clothing was damaged by your machine located at 3480 Metavis h Street please note that I am not in the least bit satisfied by the treatment which you accorded me and with the present state of affairs. Also please note that I have a long memory.

I find it interesting that your representative Mrs. Demakian first simply refused my invoice for associated costs, and then only when I went through the effort of preparing a civil action did you stand up and take notice. You then went through the crass motion of buying me off with a cheque for $12.00, assuming, and quite rightly, that I would not pursue you through the legal jungle for $8.62.

However, as far as I am concerned, you still owe me $8.62, and there are other ways of recovering this besides lawsuits. So here is what I am doing and what I will do:

1. As an alumnus of ΔΚΕ fraternity, when the discussion of obtaining a washing machine for the fraternity house came up, I got myself appointed to the comitte in charge. I dissuaded renting from Coinamatic, and instead purchased a machine. This action was taken solely because of your niggardly attitude towards me.

2. Now that the new student elections are over at McGill, it so happens that I am a friend of the new Internal V.P. I intend to submit a dossier to him to persuade him to have your machine taken out of the Student Union.

3. I am not sure if your machines are located in the student residences. When I get around to it, I will investigate this, and if they are, I will make representations to my personal friend Stanley Frost, V.P. Admin. to have them thrown out.

4. I am a social friend of Bruce White, Pres. Phi Kappa and the Interfraternity Council. I will be making representations to him to ensure that no fraternity on campus will ever use your machines.

5. I also happen to be a close friend of Jim Harmont, who has just taken a position a Chief Co-ordinator of the Canadian Institute for Public Interest Rights. He will be delighted to investigate your firm.

I am going to force you to live up to your responsibilities. Presuming that you would rather avoid having me undertake this campaign, I expect your cheque. It is now $9.45, including interest.

Regards, Jan van Eck

Phase #3: Van Eck says "no deal" and says that he will publicize his unfavourable opinion of Coin-a-matic.

ORENSTEIN, RUBY, MICHELIN, ORENSTEIN
ADVOCATES, BARRISTERS AND SOLICITORS
TEL. 848-0141

March 13, 1974

Dear Sir:

Re: Coinamatic Inc.

Your letter of March 1, 1974 addressed to our above client has been handed us for attention and reply.

We are instructed to notify you that your proposed activities mentioned in your said letter constitute a violation of law and unless we receive a letter of retraction of your alleged intent, we are instructed to take proceedings by way of injunction against you without any further notice or delay.

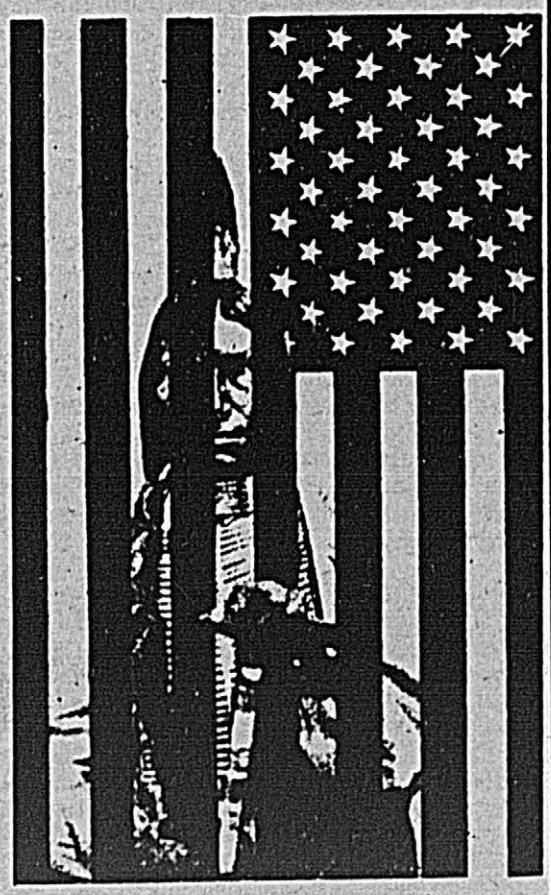
You are given a delay of three days at the latest to reply to this present letter in the above-mentioned matter, failing which proceedings will be taken.

Yours very truly,

ORENSTEIN RUBY MICHELIN ORENSTEIN

Phase #4: A "Threatening' letter from Coin-a-matic's lawyers.

CLYDE BELLECOURT
American Indian Movement
Defender of Wounded Knee



SPEAKS
March 25
8:00 p.m.

Student Union
Ballroom

Co-Sponsors: Workers' Support Committee-McGill
Debating Union - ASUS

Joyce play leaves too much unsaid

by Arnold Bennett

James Joyce has left Paris and is doing very well indeed in Montreal. Neil Vipond gives a tour-de-force performance as the controversial Irish novelist, in the Centaur Theatre production of **Mr. Joyce is Leaving Paris.** The play opened shortly before St. Patrick's Day.

In his play (the current production of which is, incidentally, the North American premiere), playwright Tom Gallacher gives us a rather unflattering picture of Joyce, whose only two virtues seem to be courage and genius. For most of the play we see him as a drunken, selfish, arrogant s.o.b., a destroyer of souls who sucks the life out of those who are foolish enough to love him and directly causes the suicide or madness of several.

All of this we learn either from Joyce's relationship with his brother Stanislaus or through his communion with four characters who are evidently the voices of his conscience. The first act, set in Trieste in 1908, sees Joyce forced to come to terms with his alcoholism by the threat of impending blindness. The second act, set in Paris in 1939, two years before Joyce's death, sees him undergoing vigorous criticism (self-criticism?) from his "voices".

The long second act is uneven in rhythm. It drags a bit at first and has several false endings, but when the "voices" descend from the audience and join Joyce on stage, the tempo picks up, and the rest of the play becomes a sort of parody on an Irish wake, complete with song and dance and eulogies that become denunciatory rather than eulogic.

Young James Joyce and family.

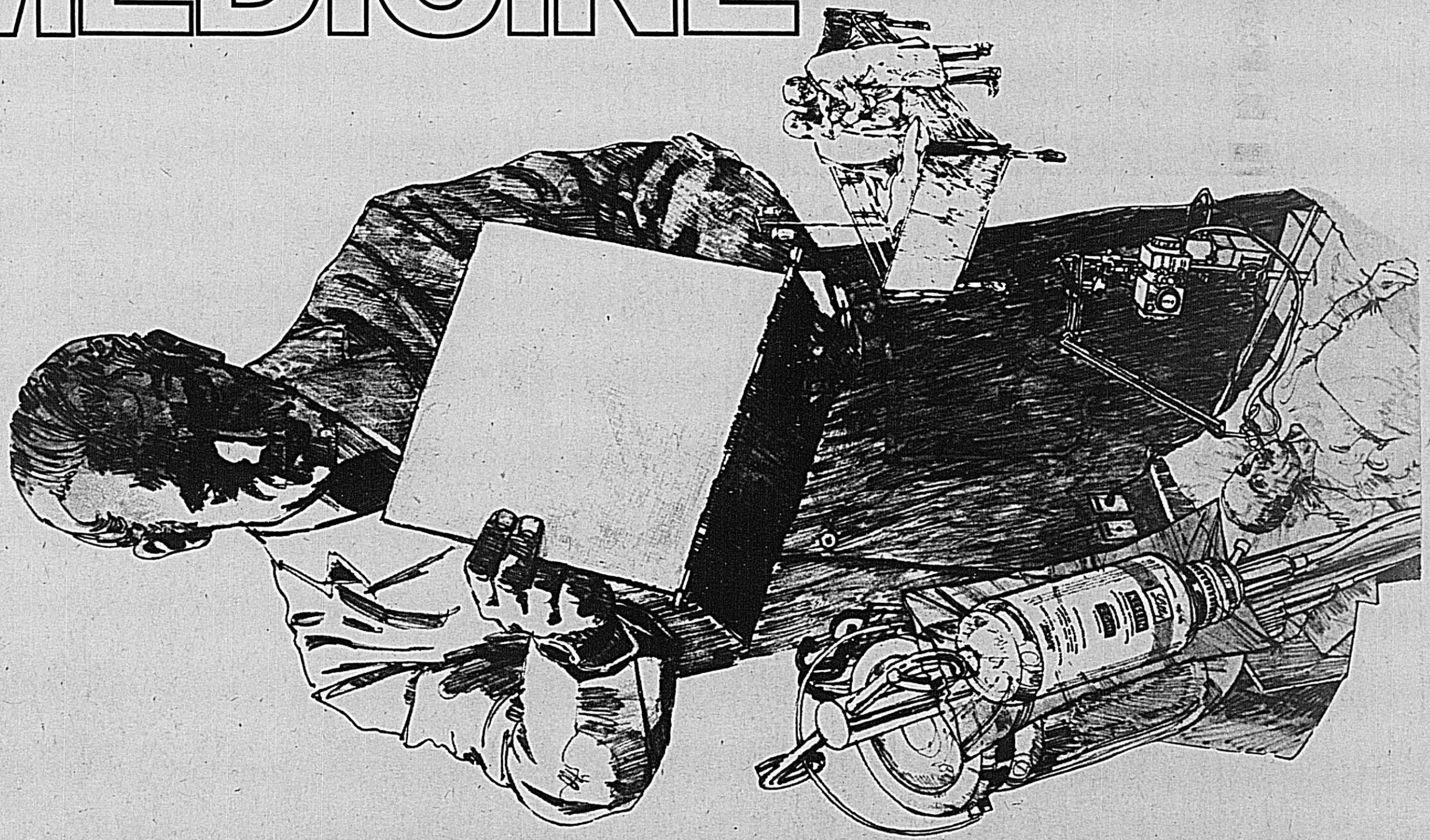
Aside from Joyce and Stanislaus, there is no other "human" character in the play. Although we hear a lot about Joyce's relationship with his wife, children and associates, we never see him relate to anyone but his brother and himself. This could be construed as a weakness.

We also hear little and see nothing concerning Joyce's relation to the society in which he lived.

Director Alan Scarfe's accompanying booklet on Joyce which can be purchased at the entrance for 25 cents, does a good job of filling in the missing background and providing some additional perspective on Joyce's egotistical, 'apolitical' and often anti-social orientation. At times this background information is necessary to completely appreciate the play.

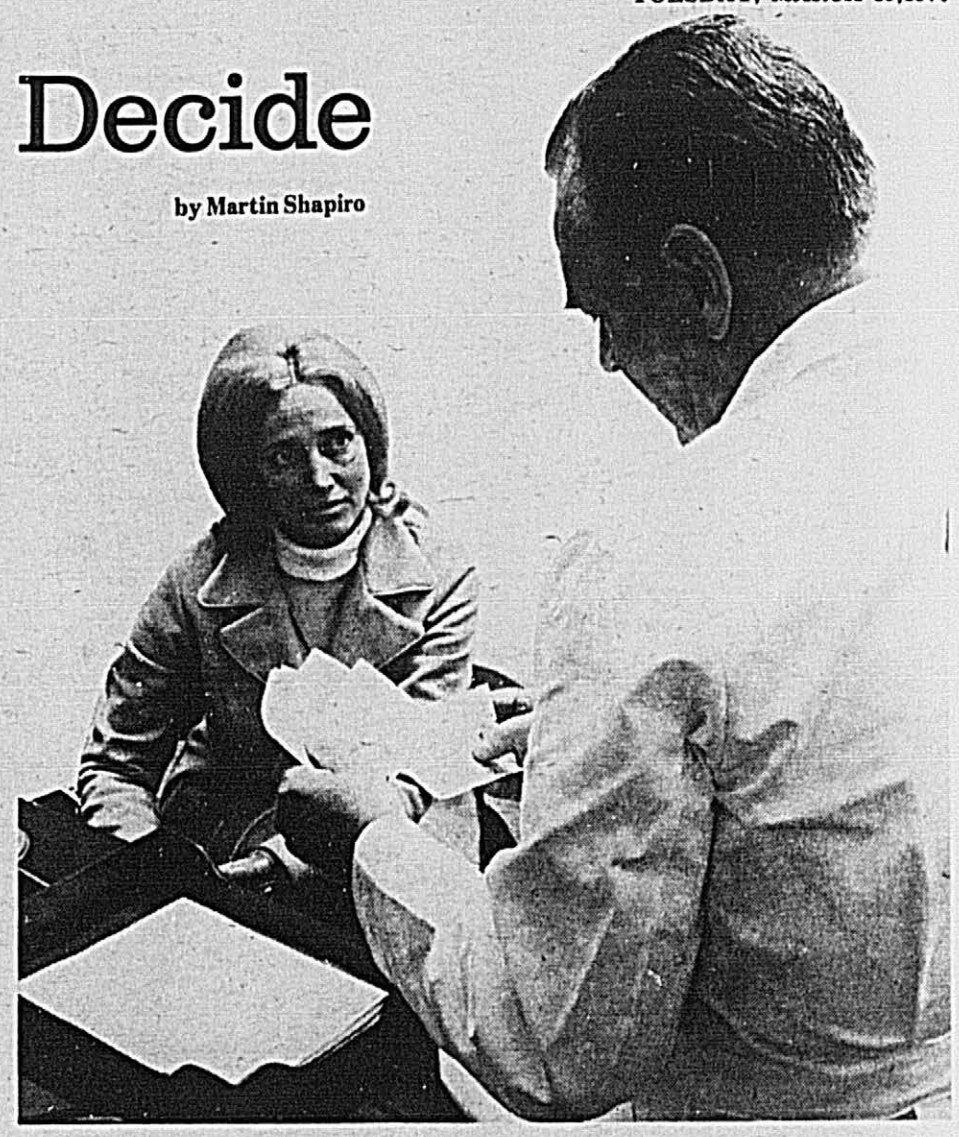
Perhaps I am somewhat prejudiced against plays that divorce characters from their social environment, but I have a feeling that this play needs the additional commentary as a crutch. Too much is left unsaid.

MEDICINE



The Patient Should Decide

by Martin Shapiro



Scene I:
An anxious 68-year-old woman visits her physician complaining of dizziness. After a brief interview and examination, the physician explains, "Your problem is caused by poor circulation. I want you to take these pills. Come back in two weeks."

Scene II:
A 44-year-old man is observed to have gallstones on "routine" x-ray examination. He is referred to a surgeon, who explains, "we have to remove your gall bladder."

Scene III:
A 50-year-old man is having a routine examination. The physician takes his blood pressure and the patient asks what it is. The physician refuses to tell him, saying, "It's quite good for your age."

Scene IV:
A 21-year-old man visits his physician, complaining of a two-day-old sore throat. The physician briefly looks at the man's throat, and tells him, "You've got strep throat." He writes out a prescription for a brand of cephalexin and tells the patient, "take these for 10 days; you'll get better," Gratefully, the patient heads for the nearest pharmacy.

None of the previous examples of typical patient-physician transactions necessarily represented cases of gross error on the part of the physician, although any of them could. What they clearly represented were decisions made unilaterally by physicians to proceed with specific forms of therapy or non-therapy.

What's wrong with these decisions? After all, haven't physicians had many years of training in how to make these decisions?

First, hardly any decision on therapy is absolute. There are usually a number of alternatives, each with relative advantages and risks. Second, many physicians do not handle the medical problems confronting them competently.

Hard to "keep up"

The proliferation of medical knowledge, (said to double every five to 10 years), makes it impossible for a physician to be aware of current attitudes, discoveries, and therapies, unless he or she is continually renewing his or her knowledge.

There is no incentive nor obligation at present to ensure that this happens. Most physicians practice for 30 to 40 years after graduation.

Consider the state of knowledge of a 55-year-old doctor who graduated in 1944. Penicillin had been introduced just about the time of his graduation. Most of the other drugs in use today had not been conceived of then.Unless he or she kept up with all the new information since graduating, the physician would only have accumulated the propaganda of drug detail men. These men would have the practitioner use expensive medications in situations when they were unnecessary or even potentially dangerous to the patient.

Economically advantageous therapy

Not all physicians who give their patients less than the best care do so because they lack knowledge of recent advances. There are some forms of therapy which are economically advantageous to the physician. For example, the hysterectomy and cholecystectomy, (respectively, the removal of the uterus and the gall bladder), are both procedures which are administered more often than necessary. A recent survey of the records of the Manitoba Health Insurance Commission showed that women living in small towns were four times as likely to have their uterus removed than were those living in Winnipeg.

Evidence suggests that physicians and their families are less likely to undergo surgery than are other people.

When a physician opts for surgery, (be he specialist or "idealistic" general practitioner who does surgery, even today) - he or she is opting for a form of therapy that is not necessarily in the patient's best interest.

Questionable surgical procedures are not the only way that physicians mismanage their patients in order to pad their already bulging pocketbooks. (The average physician's declared net income before taxes in 1971 was $41,000).

Some patients are brought in for weekly injections of doubtful value at unquestionable cost. Other patients are given unnecessary prescriptions for antibiotics after an office visit because determination of a more suitable therapy would require more detailed examinations and, perhaps, some outside reading. (Also, it has often been alleged that physicians receive kick-backs from pharmacists for business provided).

One to one and one-half hours is a reasonable estimate of the time required to do a proper medical history and physical examination on an initial visit. How many practitioners are willing to do this, particularly when they can charge medicare just as much for a visit that takes five to 15 minutes?

Medicine: a closed profession

There are many procedures which could competently be handled by people with less training than a physician. The medical profession, however, has jealously protected itself from any intrusion by paramedics into primary care roles. Studies in Memphis, Tennessee; Boston, Massachusetts; and Burlington, Ontario, have shown that nurses and others with special training can do as good or better a job of caring for people with certain chronic diseases (such as diabetes and hypertension) as physicians. These programs will be tolerated in places where the practitioner has more business than he or she can handle, but it is unlikely that they will be tolerated in situations where they threaten the financial position of the physician.

Alienation of labour

A classical picture of alienation of labour is the inadequate care provided by doctors. It is more profitable to see patients than to read journals or to take refresher courses. It is more profitable to remove an organ than to see if the patient can get along without an operation. It is more profitable to administer the treatment which occupies the least amount of one's time when the fee is fixed. It is more profitable not to hand over simple tasks to people with lesser training, if it means a reduction in one's own income.It is more profitable to see a patient as often as possible for as little time as possible at each visit. In many of these ways, the physician maximizes his profit at the expense of the patient.

It would, however, be naive and inaccurate to suggest that all practitioners act this way most, or even much of the time. Many feel that each decision is made with consideration for the patient's best interests.

Future models of decision making?

A model of physician-patient relationship in which the patient, rather than the physician, would make the major decisions relating to the form of therapy for his or her disease should be considered. Had this relationship existed, the four scenes at the beginning of this article might have been written differently:

Scene I: *Physician: "The problem seems to be your circulation. There are some pills you ought to take. They will help you."*
Patient: "How are the pills supposed to correct the problem? Is there any evidence that they will do this? What do the pills cost?
Physician: [if honest]: "The pills are supposed to increase the circulation to your brain. There is no objective evidence that they do this. The pills are quite expensive. Experts in the field have indicated that there is no evidence that patients benefit from this therapy."
Patient: "go to hell."

Scene II: *[Not every patient will know which questions to ask. If we assume that he has the right to make decisions concerning his own health care, then his physician has a responsibility to provide him with the necessary information, whether he requests it or not.]*

Physician: "I think we ought to remove your gall bladder. You have gallstones, which, at some time in the future, might obstruct your bile duct and make surgery more risky. If we operate now, you will miss work for a month or so. It will be somewhat longer if you have any post-operative complications. Your chances of dying are about one per cent if we do the operation now, somewhat higher if we wait for an acute attack. An alternative would be to try to dissolve the stones with medication."
Patient: "Well, why take unnecessary chances. Let's try to dissolve them. Even if we can't, I'm not sure I want an operation."

Scene III: *Physician: "Your blood pressure is 160 over 98. That is somewhat higher than normal, but I've seen many people do very well for many years without treatment. There have, however, been studies done recently which showed that a level of blood pressure such as yours is associated with an increased risk of heart attacks and strokes. Medication has been proven to reduce the blood pressure and the associated risk. Our alternatives are: to do nothing, to put you on a special diet, or to put you on medication."*
Patient: "Both my parents died of strokes. You better give me the pills, but I can't afford anything too expensive."
Physician: "There is a good chance we can control your blood pressure with pills costing one or two cents a day."

Scene IV: *Not all physicians will adjust readily. Old traditions die hard:*
Physician: "You've got strep throat. Take these."
Patient: "How do you know?"
Physician: "I don't but I'm too lazy to do a culture to find out."
Patient: "Well, I think I'd rather be sure before I take any pills. And by the way, is the brand of cephalexin you prescribed the cheapest drug that can do the job if I have strep throat?"
Physician: "I'm not sure. A detail man told me it's a great drug."
Patient: "Why don't you find out?"
Physician: "O.K. I'll look it up in that book the government sent me. Let's see if I can find it. I've never looked at it before. Here it is. Let's see. Oh my gosh! A 10-day supply would cost you about 25 dollars. If we gave you penicillin instead, it would cost you only two dollars."
Patient: "I see. Take a culture please. Then give me penicillin if necessary."

In each of these scenes, a number of innovations has been introduced. First, the physician has been able to explain medical problems to non-medical people by avoiding the use of technical jargon. Second, the physician has been obliged to become familiar with the scientific basis for, as well as the social and monetary cost of each of the alternatives and their relative indications. Third, the patients have made the decisions concerning their own care. Fourth, the transaction took more of the practitioner's time. Fifth, in the examples presented, the decision made was a better one than the physician might have made alone.

Clearly, the best decision about a course of treatment can only be made by a person with the most facts possible at his disposal. A practitioner who doesn't bring a patient into the decision making process, is not likely to gather together the necessary information if it is inconvenient for him to do so. To make the correct decisions in the above scenes, a physician would have had to have read articles, which many, (if not most), physicians are ignorant of.

By ending the medical profession's monopoly on decision making, patients would probably ensure themselves better care than they presently receive.

The medical profession is, however, unlikely to accept such a change in its role, particularly if one examines the logical consequences of such a break with tradition.

Medical jargon oppressive

If medical jargon is minimized in the decision making process to give patients a voice in their own care, then it can surely be removed from the interactions of health workers.

At present, all decisions relating to the

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Medicare: the Two Caste System

by David MacLean

The advent of universal health care insurance in Canada has brought better care for the rich but the poor have been left with a largely unchanged health care system. Though health care insurance has admittedly relieved some of the injustices of the private enterprise, entrepreneurial system of care that previously existed, a caste-like system nevertheless persists.

Two distinct systems of health care exist in Montreal - one for the social and economic middle and upper classes and the other for the poor and lower working classes. The latter is in many ways inferior, more dehumanizing, and certainly discontinuous and inconsistent.

Accessibility

The inequalities between the two systems of health care include accessibility to the ongoing care of a private physician, accessibility to hospital care, and differences in comfort and convenience.There are certainly differences in efforts taken to preserve the patient's sense of dignity. In spite of these differences, the cost of the system to its beneficiaries is relatively higher for the poor.

The most obvious inequality is in accessibility to health care. The preservation of large teaching-hospital outpatient clinics in Montreal provides the bulk of service to low-income patients. Wealthier patients can easily enter into a private practice relationship with a specialist or general practitioner that bypasses the clinic system while the poor cannot.

The physician recruited from the upper and middle classes, finds himself more comfortable and emotionally gratified in a doctor-patient relationship with those from his own background because they can communicate on the same level.He is less often frustrated by inadequate patient compliance from these clients and finds himself more willing to carefully explain or rationalize a therapeutic regimen.

When dealing, however, with a low income group patient the doctor will feel less comfortable and may subconsciously desire to pass his patient off to some other doctor. A low income patient, following an in-hospital consultation, is unlikely to be referred to the doctor's own office for the follow-up consultation.

Quality of care

The importance of care under a private physician must be understood. The quality of care, in terms of laboratory investigation and therapy provided, may be as good at the hospital clinic as at the private physician's office. Yet at the hospital clinic, the patient is almost guaranteed discontinuity of care, frustrating hospital bureaucracy, and the impersonal environment still prevailing at most outpatient clinics.

For the common problems in medicine including high blood pressure, diabetes, psychosomatic complaints, - it is not just the first visit that is crucial. It is the establishment of a doctor-patient relationship that will ensure follow-up by the doctor and willingness of the patient to follow prescribed therapy. In this sense, quality of care at large clinics, regardless of diagnostic procedures and recommended treatment, is inferior and discontinuous.

Aside from suffering directly from the prejudices of the doctor, the patient must also meet the practitioner's secretary or nurse who may have the same prejudices. Distant appointment dates for what are often acute or long neglected needs are prevalent among the poorer people.. The stultifying atmosphere of the physician's office also sets up an informal barrier.

The vicious circle of ignorance, prejudice, and even greed continues to reinforce the endless cycle from emergency room to acute hospitalization to out-patient clinic to impersonal care and poor follow-up to emergency room for some patients.

Not all the unfair practices of the system can be attributed to unconscious prejudices. There are many physicians, still with admitting privileges at the Royal Victoria Hospital or Montreal General Hospital who opt out of the health care system altogether, thus insuring the exclusiveness of their patient population.

Privileged seclusiveness at Ross

The preservation at the Royal Victoria Hospital of the Ross Pavilion for private patients is an amazing example of how deeply entrenched is the class-oriented system of health care. At the Ross, patients, who are admitted under private physicians only, pay $15 to $20 a day extra for hospitalization in plush private rooms. These extra fees,(the bulk of their hospitalization costs) are up to $140 a day more than the cost of care for a public patient. They are subsidized by health care insurance.

The cost to the taxpayer, however, is not just $140. Being $15 to $20 cheaper than a good hotel, these private luxury rooms are used by many wealthy patients as places to relax and to be waited on. This is accomplished by having patients admitted for a "rest", an annual check-up or for other relatively minor reasons for which the poor would have no chance of being hospitalized.

Furthermore, the private patient with an acquiescing physician may obtain "emergency" admission and gain direct access to the hospital ward without first being seen by the emergency department. He or she thereby avoids the long, often dehumanizing, but rigorous screening procedure required to gain access to a public medical ward.

Monetarily the low income wage earner pays a far greater percentage of his income for health care, and the overall quality and comfort of his own care is inversely lower.

The low income patient pays the same health care insurance premiums, has the same or even higher drug costs (unless purchasing at a hospital pharmacy) and if chronically ill assumes other non-apparent costs such as transportation which he or she is less able to afford than the high income individual. The well-to-do are able and willing to pay extra for the more luxurious and personalized services of which the Ross Pavilion is only one example.

Medical class system

In summary, there still exists in Canada, and particularly in Montreal, a caste system of medical care despite universal health care insurance, and despite supposed equal opportunity for equal health care. In some ways the barriers are explicit - the extra fee charged by many specialists and the privileged seclusiveness typified by the Ross. In other ways the differences are implicit or covert such as the funnelling of low-income patients to hospital clinics or the inability of physicians to respond to the needs and attitudes of low income patients.

The continuing class system of health care is a reflection of our existing social structure. Huge differences in personal income, (e.g. between physicians and other health team members), and in social and economic opportunity, can only reinforce current inequality.

Ours is a social system based on private gain and profiteering, as seen in downtown Montreal's current wave of self-destruction . Until this is replaced by an ethic based on social awareness and responsibilty there will never be the climate necessary to transform two isolated health care systems into one that is equal for all.

David MacLean is an intern at the Royal Victoria Hospital.

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care of patient are arrived at by one physician or by discussions among several physicians. Nurses, physiotherapists, dieticians, and others do not take part in such conversations mainly because the jargon used leaves them embarrassingly behind.

Generally, the purpose of medical education is to provide future physicians with sufficient jargon to oppress their patients and fellow health workers. Jargon could be virtually eliminated from most conversations at little cost in terms of efficiency.

As another manifestation of the alienation of physicians from their work and fellow workers, they cannot conceive of surrendering authority by sharing decision-making. Those who have not gone into medicine exclusively to make money have, for the most part, done so for the satisfaction derived from the psychosocial position of the physician (with respect to patients, health workers, and community). Clearly, this would be compromised considerably were the power of the physician diminished.

Unalienated medical care

One can conceive of unalienated medical care. A change in the decision making process is but one step in that direction. Practitioners should be paid salaries which reflect their needs and the amount of work which they do. Piece-work medical practice, as it now exists, offers physicians an incentive to maximize the profitability of their work.

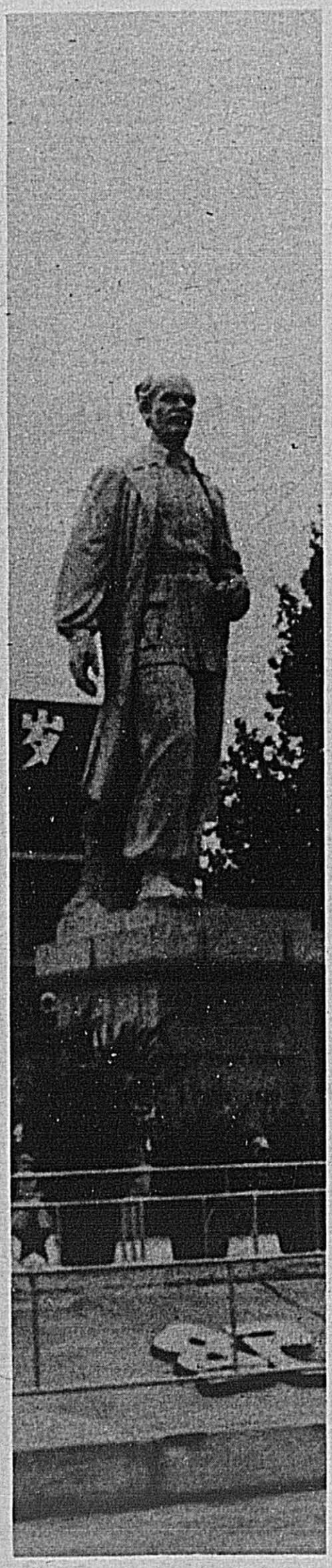
Physician-patient decision making important

Role-playing will have to end if health care is to become unalienated. A useful first step in this direction would be to stop calling the physician "Doctor".

Besides sharing decision-making with patients and others, the physician should cease to occupy the top rank in a hierarchy. He or she should be regarded as another health worker, with more knowledge than some about particular (but by no means all) aspects of a patient's problem. It should be his or her duty to put this knowledge at the disposal of the team of health workers as well as at the disposal of the patient so that appropriate decisions might be made.

One Man's Long March

The life



by Nigel Gibson

Bethune was a unique Canadian, a unique human being, yet shaped by both his country and the contemporary world. He was truly a neo-Renaissance figure, driven by the necessity to experience and enrich all of life. To him encrusted conventions were silly; love, a great hunger and an affirmation of life; medicine and surgery, his art, his work, and his commitment; the growing brutality of our world a personal wound.

At the end, his confrontation with death as a surgeon-soldier was a natural response to the cry of the starving, the downtrodden, the brave on all the battlefields of freedom.

He was a man who achieved painful consciousness of his weaknesses. But rather than succumbing, he achieved greatness in vanquishing them.

Deliberately he abandoned the role of sybarite, roisterer, and roué, to become the front-line doctor, the guerrilla in straw sandals, the revolutionary, for whom life was no more than a few handfuls of rice for sustenance, and surgery performed in the midst of bloody battles. He knew comradeship with strangers who called him brother, and his indestructible strength lay in his vast dream of remaking the world. At the end, his personal life had become completely merged with the fate of the world's peoples. Today, wherever their cause has succeeded, he is honoured. Wherever they must still fight on, he is a banner, and a call to arms.

Ted Allan and Sydney Gordon
The Scalpel, the Sword

Henry Norman Bethune was born on a cold and stormy day in March 1890, in a clapboard manse, on the outskirts of the little town of Gravenhurst. His father was an outspoken Presbyterian minister, and his mother a profoundly religious one-time Presbyterian missionary.

They were a stern, strongwilled couple and they raised their children strictly, in accordance with the dictates of their Scottish upbringing, and those of their church.

On one occasion, during Bethune's early years his father dragged him out of the house, pushed his face into the ground and made him eat dirt in order to teach him humility.

Norman grew up in the Ontario countryside, and came to love its pine forests, lakes, hills, and summer skies, and they would be forever part of him.

Even as a boy, Bethune exhibited a great curiosity, an insatiable love for adventure, and an almost callous disregard for his own safety, which, together with his nervous energy would characterize his later years.

By the age of eight, he had already made up his mind to be a surgeon. He converted the attic into a makeshift laboratory, and dissected anything he could lay his hands on, much to the horror of his poor mother.

Medical school interrupted

When the time came for Norman to go to college, the Bethunes moved to Toronto, so that he could attend the University of Toronto. Though hard pressed by his studies and forced to work his way through college, Bethune still found time to draw, paint and sculpt. He was just one year away from his MD when the First World War broke out. Like so many other young men of the time, Bethune dropped everything and enlisted.

He was posted to France as a stretcher bearer with the 1st Canadian Division Field Ambulance. The initial thrills of the big adventure soon gave way to horror and disgust in the face of the slaughter and devastation of trench warfare. Badly wounded at Ypres, he was invalided home where he completed his degree and re-enlisted. The end of the war found him in France.

Demobilized in England, Bethune began his first internship in London's famous Hospital for Sick Children on Great Ormond Street. He combined his internship with a flourishing free-lance art dealership that allowed him an extravagant and uninhibited life style. His flat became a gathering ground for writers and artists, and was the site of many boisterous all night drinking sessions.

A young Canadian pediatrician at Great Ormonds, Dr. Graham Ross remembers that Bethune "seemed to breeze into the place rather like a breath of fresh air from the sea, and one was impressed at the time by his, not aggressiveness, but his confidence, his outlook on the world. One felt that he had no worries, that the world was his oyster...and that he was there to get it."

Another of Bethune's colleagues at Great Ormonds, an English doctor, is not so charitable. To this English doctor Bethune seemed "...a trifle bumptious and slapdash, and very unorthodox even for a Canadian..."

Unorthodox practice

He was certainly unorthodox. Setting up his practice in the countryside, he caused quite a stir among the quiet country folk by driving a Model T Ford around the town at top speed, and jumping on any excuse to host frequent parties for the village children.

In 1922, after becoming a Fellow of the Royal College of Surgeons, Bethune married Frances Campbell Penney, the only daughter of a prominent Edinburgh family.

Together the young couple flitted across Europe, burning up Frances' inheritance, and finally winding up in Detroit where Bethune set up his first office, in the center of what turned out to be the city's red light district.

Bethune soon learned a lesson his professors had never even mentioned: those who most needed his services were those who could least afford to pay for them. Even as he worked his way up into select medical circles, Bethune found himself drawn more and more towards the plight of the poor all around him.

He became increasingly bitter and outspoken in his criticisms of his colleagues. "Some of them," he fumed, "have as much right to be practising as the medieval barber. I'd weed out half of them to begin with and put them to work behind a counter. And I'd see that the remainder understood they were doctors, not men of commerce."

Needless to say, these remarks of his did not endear him to his colleagues. Their shrill denunciations, however, only served to spur Bethune on in putting his principles into practice.

Bethune gets TB

Eventually the strain of his lonely struggle caught up with him, and he developed a serious case of tuberculosis of the left lung. Convinced that he had not long to live, Bethune divorced Frances, sending her back to Edinburgh with instructions to enjoy the full life ahead of her, and to begin again without him.

Resigned to his fate Bethune was admitted to the Trudeau Sanitorium at Saranac Lake, New York.

While Bethune was a great doctor, he was also, just as certainly, a terrible patient. Bored, and resentful of the enforced bed rest prescribed for him, Bethune took to strolling around the hospital clad in his pajamas and a top hat, making disparaging remarks about the validity of the treatment he was receiving.

He further outraged the directors of the sanatorium by sneaking out of the hospital grounds, every now and then, for a night on the town, or by hosting clandestine parties for the nurses with bottles of wine smuggled in from Montreal.

Even as he prepared for the final and fatal onslaught of the disease, Bethune read about a new technique that was being used by a few doctors to treat pulmonary tuberculosis. The technique, known as artifical pneumothorax, consisted of pumping air into the chest cavity so as to collapse the afflicted lung, giving it a chance to heal.

Bethune demanded that the technique be tried on him. At first the doctors hesitated, but eventually he had his way. The treatment was a complete success; within two months he was fully recovered and pronounced fit to leave the hospital.

Surgeon at RVH

In January 1929 Bethune began a new career as a thoracic surgeon at the Royal Victoria Hospital in Montreal. Frances soon joined him and they were married again. For a while Bethune was very happy. He particularly enjoyed his teaching appointment at McGill.

He was an interesting lecturer with a dry-witty sense of humor, and he allowed a very relaxed classroom atmosphere. He permitted smoking during his lectures, and in fact freely offered his own cigarettes.

In addition, he held frequent Saturday bull sessions with groups of students over mugs of beer in downtown taverns.

One of his students recalls that Bethune "hated obscure...baseless arguments...That was the kind of thing we liked because students in our day were inclined to accept things unquestioningly. They were expected to vomit these things out on the examination paper. As a student, if you disagreed with Bethune, he welcomed that. This was very valuable to him. He was a breath of pungent air, but it was good..."

Bethune's reconciliation with Frances, however was shortlived, and this time it was his wife who asked for a divorce.

On his patients' level

Heartbroken, Bethune took consolation in his work. He was a good doctor, impressing everyone with his incredible energy and dedication. As a surgeon he developed a reputation for speed and dexterity as well as for innovative and daring surgery.

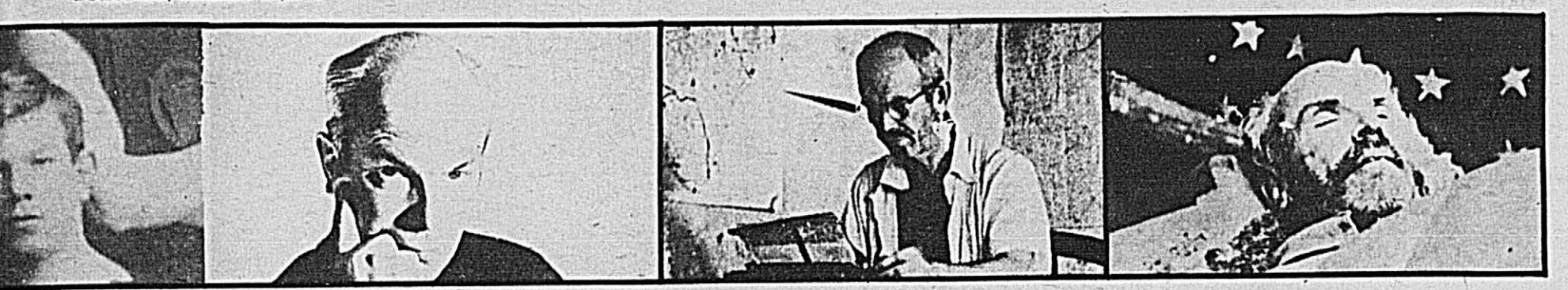
He was also completely involved on a human level with his patients, and they worshipped him.

A nurse who worked with Bethune recalls that, "A patient he operated on became almost his personal possession. He would visit a patient two or three times a day until they were well on their way to recovery, delighted when they did well, always serious and always encouraging them. When complications would arise, he would become very upset and never stop worrying..."

Another of his assistants recalls that when Bethune lost a patient, "nobody on the staff liked to be around him, because he would cry or rage in his frustration and despair."

Conflict with conservatism

Bethune's approach to medicine, coupled



e-long struggle of Henry Norman Bethune

with his flamboyant lifestyle, earned him many powerful enemies among the doctors at the highly conservative Royal Victoria Hospital.

The doctors particularly resented Bethune's tendency to question every concept and opinion of his colleagues and his superiors. Unlike most of them he openly subjected all clinical and surgical techniques, no matter how fundamental to rigorous criticism.

Some of these doctors went as far as to accuse Bethune of "dangerous recklessness," and of using his patients as "guinea pigs." Bethune was undaunted by their veiled and vicious criticisms.

"The trouble," he told one of his critics, "is that, by nature, you shoot butterflies with a shotgun, and I like to hunt elephants with a bow and arrow."

Bethune was more concerned with a strange contradiction that had been bothering him for some time.

There's something wrong," he would say. "The more advanced our curative surgery, the more cases of TB we get. Precisely at the moment when scientific knowledge on how to attack the disease has reached its highest point, the incidence of the disease has equally reached its highest point."

A case in point was the mortality rate of tuberculosis in Quebec; the highest in Canada. In 1925, 3000 Quebecois died of the disease.

The answer, Bethune soon realized, had its roots in the poverty and malnutrition that spawned the disease—in an economic system that blamed its woes on overproduction while half the world shivered in hunger and misery. "The right to a healthy life," he stated indignantly, "should not have to be purchased, like a can of beans at the corner store."

Questions the medical system

What was needed was "a new medical concept, a new concept of health protection, a new concept of the functions of the doctor." Further studies convinced him, however, that this would not be possible under the limitations of the existing political and economic system.

A visit to the Soviet Union, that included an extended tour of Soviet hospitals and sanatoriums showed him what could be done outside the system.

In 18 years, almost half of which were spent in rebuilding the country's ruined economy, the Soviet Union had cut the incidence of tuberculosis by more than 50 per cent. The rest homes, convalescent homes, and sanatoriums were the most lavish he had ever seen, with industrial workers receiving priority in institutional treatment—the exact reverse of the situation back home. In the dispensaries and sanatoriums all treatment was free, not as a matter of charity but as a constitutional right of the individual.

On his return to Montreal in September 1935, Bethune declared that "Russia presents today the most exciting spectacle of the evolutionary emergent and heroic spirit of man which has appeared on this earth since the Reformation."

Joins the Communist Party

A few days later he joined the Communist Party. His formal membership in the party was kept secret in order to protect him professionally. But in a country in the grips of the Great Depression, wracked by division, crisis, and unprecedented human suffering, he made no attempt to hide the fact that he was no longer merely a reformer, but a revolutionary, consciously engaged in the great struggle to change the world.

Around this time Bethune founded the Children's Art School of Montreal, which afforded slum children, for the first time an opportunity to develop their artistic potential.

The artist's role

Bethune had some very definite ideas on what the role of the artist in society should be. "The function of the artist," he once wrote, "is to disturb. His duty is to arouse the sleeper, to shake the complacent pillars of the world. He reminds the world of its dark ancestry, shows the world at its present, and points the way to its new birth. He makes uneasy the static, the set and the still."

The art school, housed in Bethune's own home, was a great success. Every Saturday, Bethune would take the children on a tour of art galleries across the city. Seldom did he appear happier.

But time was running out. The dark clouds of fascism were spreading over the European horizon. Hitler, Mussolini, and Franco were on the move. Local fascist groups were springing up all over North America.

Bethune was deeply troubled. "The insanity is spreading too quickly," he warned his friends. "They've begun in Germany, in Japan, now in Spain and they're coming out into the open everywhere. If we don't stop them in Spain while we still can, they'll turn the world into a slaughterhouse."

Bethune at the age of 46 was at the top of his profession. His innovative surgical techniques and his development of a whole line of improved surgical instruments had earned him worldwide recognition as a first rate thoracic surgeon. Medical specialists from all over the world came to Montreal to study his work. In a few more years he could look forward to a comfortable retirement.

However, when the Committee to Aid Spanish Democracy asked him to head the medical team it was sending to the besieged city of Madrid, Bethune gave up everything and left for the battlefields of Spain. It was December 1936.

In the Spanish Civil War

While in Spain Bethune struggled to set up front line medical teams to aid the heroic, but hopelessly disorganized and ill-equipped Republican army.

He made medical history by successfully establishing mobile blood transfusion units, equipped to provide transfusions at the front while fighting was in progress. The technique would prove to be instrumental in saving the lives of thousands of soldiers who might otherwise have bled to death on the battlefield, or between the front and the base hospital.

In 1937 he returned to North America to plead the case of Spanish democracy across the width and breadth of the continent. He was no longer prepared to conceal his communist affiliations.

In Saskatoon he told a packed legion hall, "You can't talk about humanity without speaking of the class struggle. I'm preaching it and the sooner people realize it, the better."

Off to China

Less than a year later, in 1938, he was on his way again. This time bound for northern China to join the guerrillas fighting the Japanese.

After a hazardous journey through the Japanese lines Bethune arrived in Yenan, headquarters of the Eighth Route Army and the base area of the Chinese Communist Party led by Mao Tse-tung.

Bethune wasted little time in evaluating the capabilities of the medical units attached to the Red Army. He found them to be in every case inadequate. There were inadequate front-line medical facilities, inadequate medical training, and inadequate supplies.

Bethune immediately laid plans for the construction of a model hospital at Sung-yen K'ou, that could be used to teach medical personnel the fundamentals of medicine, basic anatomy, and physiology.

Bethune took complete charge of the project. He supervised the construction of the hospital in an unused Buddhist temple, wrote the curriculum and the textbook, and trained the staff.

When offered the principalship of the school, however, he refused, saying that he was needed at the front.

Once at the front, he set about the task of organizing mobile medical units that would go into battle with the combat troops, and provide first aid medical treatment and blood transfusions to wounded soldiers in the field. The results were spectacular, and they spurred Bethune on to even greater effort.

In a letter to Mao Tse-tung and the Military Council Bethune wrote: "The time is past and gone in which doctors will wait for patients to come to them. Doctors must go to the wounded and the earlier the better."

As if conscious of his fate, Bethune made every minute count. Sometimes operating continuously for days, teaching, rushing to battles, operating, returning to sketch plans for the construction of model hospitals, working on his textbooks. Pausing now and then to snatch a few hours of fitful sleep, only to awaken and haul his worn and emaciated body back to the operating table.

No time to rest

His assistants worried for his health, and when their repeated pleas to slow down fell on deaf ears, they appealed directly to Red Army commander General Nieh.

Nieh summoned Bethune to headquarters, and advised him to get some sleep. When Bethune refused, Nieh ordered him into a nearby room to rest for six hours.

For a few minutes Bethune did as he was told, retiring to the room to sulk quietly in the dark. Moments later however, he dashed back into the general's office and shouted "in respect to medical matters I will not take orders even from you." Turning on his heels he stomped angrily out of the office, and within minutes was back at the operating table.

In the evenings he used to visit the wards armed with a bowl of soup—his ration for the day. He would approach a wounded soldier and ask him, in broken Chinese, how he was feeling after his operation. When the soldier opened his mouth to answer, Bethune would quickly shovel a spoonful of soup down the startled soldier's throat. When the wounded discovered, however, that Bethune was sacrificing his own meagre rations, they raised a tremendous fuss and Bethune was forced to give up the practice—only to try again somewhere else.

His dedication was such, his reputation was such, the love for him was such, that Chinese soldiers would attack Japanese outposts with the cry, "Attack! Bethune is here to take care of the wounded."

A great hero

The impact of his one short year in China can best be gauged by the fact that today, more than 30 years after his death, his presence remains as vibrant as ever, undiminished across the width and breadth of China.

For millions of Chinese Bethune remains one of the greatest heros of all time; a shining example of selflessness and dedication on which to model their lives.

In October 1939 Bethune contracted a bad case of septicaemia, after cutting his finger while operating without any gloves, on a wounded soldier with an infected head wound.

With their medical supplies blockaded by the Japanese and the treacherous Kuomintang forces, his medical assistants were powerless to save him.

He died in the early dawn hours of November 12 in a peasant's hut high in the icy mountains of West Hopei.

At Yenan, units of the legendary, undefeated Eighth Route Army, assembled in the mountain passes in massive tribute. There were tears in the eyes of the tough Red Army soldiers as they stood silently row upon row. Then as one a mighty cry arose. "Down with the invaders!" they shouted: "Remember Dr. Bethune!" "Everything for the struggle! Remember Dr. Bethune!" "Long live free China! Remember Dr. Bethune!"

Hours later the Eighth Route Army swept down from the mountains closing the trap on the encircling Japanese forces, and killed the Japanese commander, his entire staff, and every enemy soldier with him.

Norman Bethune rests forever in the Mausoleum of Martyrs, in the city of Shih Cha Chuang, southeast of Peking. There in the midst of an immense and beautiful park, not far from the Bethune International Peace Hospital and the Bethune Medical School, in a quiet disturbed only by the soft rustle of the wind in the trees, Norman Bethune lies in peace at last.

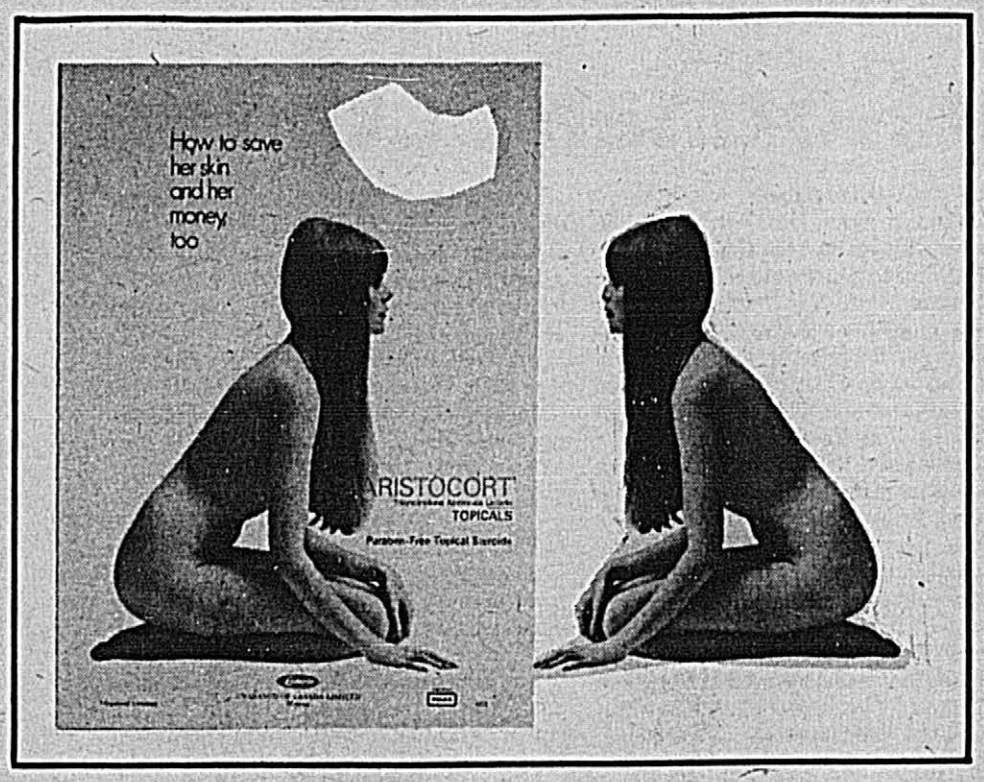
Recommended Reading

The Scalpel, the Sword
The Story of Norman Bethune
Ted Allan & Sydney Gordon
McClelland and Stewart
$4.95

Bethune
Roderick Stewart
New Press
$10

Most of the material for this story was culled from the above books. Both are well-written, thoroughly engrossing, and cast a fascinating light on the amazing life of the man, too long a stranger in his own land. Each book in its own way complements the other. I cannot recommend them too highly.

The Public and the Drug Industry



by Stephen Bezruchka

Drug companies use techniques of advertising, promotion, and detailing in an effort to persuade physicians to prescribe certain drugs and to reinforce trademarked or brand names in the minds of health workers.

The techniques, well known to health professionals,include journal advertising, flyers and circulars in the mails, distribution of samples, visits by detail men, dinners and entertainment for physicians, and display booths at conventions, medical meetings, and hospitals.

In 1966 the amount of money spent by the drug companies on such promotion in the United States exceeded $600 million, almost $4,000 per practicing physician per year! Presently such costs exceed a billion dollars a year. Research costs amount to roughly one tenth of this figure. The return on such investment in advertising is substantial and it contributes to much higher prices for drugs.

Such practices lead physicians to prescribe too many drugs too often, to prescribe costly drugs of unproven clinical value, to prescribe drugs with serious toxic side effects when there are equally effective less toxic agents available, and to prescribe powerful and potentially toxic drugs for minor conditions.

As a result, doctors often increase the costs to their patients who could obtain drugs less expensively as generics or over-the-counter preparations. Indeed, the price differences can be substantial: for example with drugs like meprobamate, prednisone, or reserpine, the most expensive product can be five to 20 times the cost of the cheapest.

Medical journal advertising

What kinds of advertising techniques are used in medical journals? First, an advertisement must attract attention. Eye catchers such as an attractive, scantily dressed woman, an inflamed anus, a baby with a dramatic skin rash, a well-known locale, or a pretty face are commonplace in most medical journals.

The brand name of the product is then prominently displayed, often with a catchy phrase to continue interest in the ad.

Ads in Canadian medical journals often omit the generic or official name so it is difficult for readers to know what is being promoted. Various claims are made for the product, some of which are unsupported and are blatantly false. (One recent example says that the product is available at "generic" prices when in fact it costs five times as much).

Sometimes the claims even appear to contradict well-established therapeutic practices. Important information on contra-indications and adverse side-effects are often omitted, or included in very small print on a far removed page and hence not usually seen.

It is most important for a drug company to have its products remembered only by its exclusive brand name. Hence, there is liberal use of it throughout the ad. This continued reinforcement helps ensure that the physician will write that name on the prescription pad. Furthermore, auxiliary health professionals, especially nurses and pharmacists, are also "brain-washed" into using the trademarked brand names and this helps keep the physician from straying into the use of the official or generic names.

There are examples of drugs which are marketed throughout the world under 50 different brand or advertising names. This creates endless confusion in communications. Brand names have no place in health care.

Generic manufacturers slandered

However, with the increasing use of generic names on prescriptions, together with an outcry on the high prices of brand name drugs, the threatened drug companies have begun an intense campaign to slander products of the cheap generic companies. They state that their products have superior bio-availability. This new term attempts to quantify blood levels generated after taking chemically similar products of different manufacturers. However there have been very few studies done on this matter, and their significance for therapeutics is yet unclear. Furthermore, products of brand-name manufacturers have shown both greater and lesser bio-availability compared to those cheaper products of generic manufacturers.

That such promotion pays off is evidenced by the fact that in the United States, the drug most commonly prescribed from 1966 to 1971 has been shown to be essentially a placebo (or equivalent to a sugar pill). Furthermore, in the U.S. in 1972, approximately seven prescriptions were filled for each man, woman, and child. This amounts to a 36 per cent increase since 1966. It could be interpreted as showing that people are quickly getting much sicker; more likely it indicates the tremendous success of drug company promotion efforts.

Role of the consumer

The health consumer should have a role in deciding his therapy. When a physician wishes to prescribe a medication or therapeutic regimen for you, ask if not taking the therapy will prevent you from recovering or improving and ask if there is good evidence that the therapy will work.

If you were to take the therapy, ask what the common side effects would be. If the physician refuses to discuss his therapy with you in this fashion, you should leave him or her. When he or she is writing a prescription, demand that it be written using the official or generic name, and that the medication be labelled with that name on the bottle.

In order to save you money, ask the physician to note on the prescription not to let it be filled with products of the most expensive manufacturers, unless he or she is prepared to give you documented evidence that those products are superior.(This price and manufacturer information is easily available from the book **Health Professionals' Manual Drug List** published by the Quebec Health Insurance Board and distributed free to all physicians practicing in Quebec.)

Ask the physician if the drug can be obtained over-the-counter without a prescription. Often physicians write prescriptions for such products.

Combination drugs

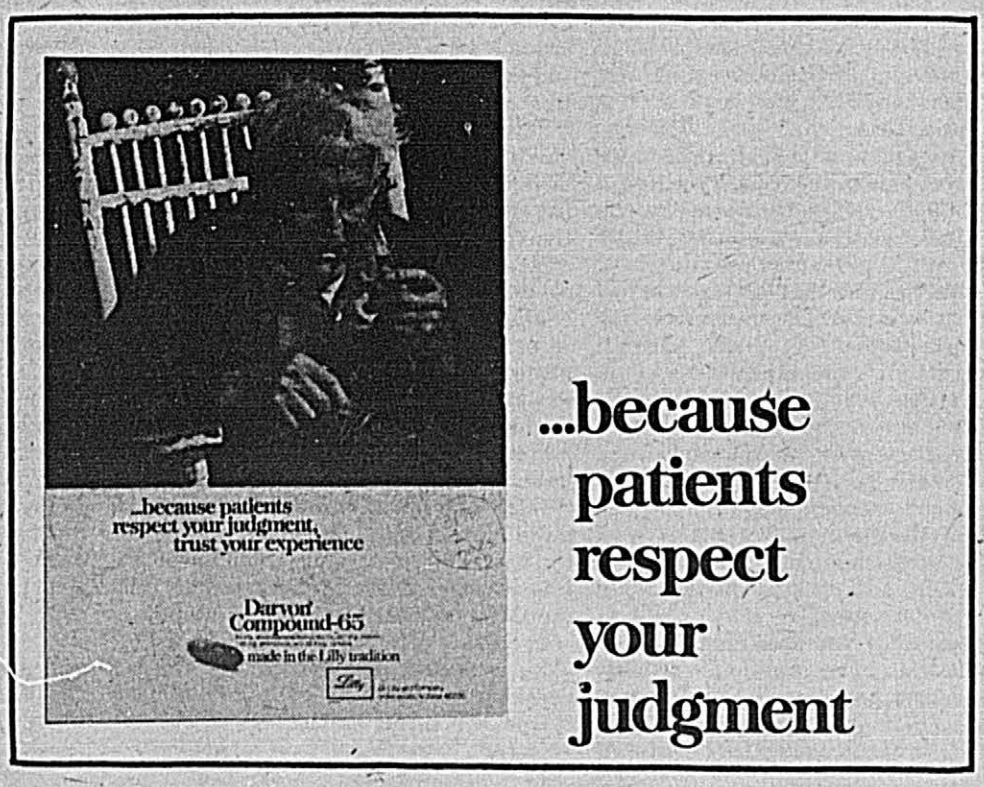
If the physician says that you are receiving a drug that is a combination of active ingredients, realize that television commercials notwithstanding, most reputable authorities frown on the use of combination drugs for most therapeutic indications.

The marketing of such products represents a very successful attempt by the drug companies to increase the number of individual chemical compounds used in medications and to increase costs and their profits. Often drugs of questionable therapeutic productivity are added in sub-optimal doses to produce a combination product. This prevents the physician from adjusting doses to optimum levels, increases the likelihood of side effects occurring without allowing them to be monitored, and subjects patients to needless risks. Furthermore, most physicians do not know the individual ingredients and their doses in the combination preparations they prescribe by brand name.

Given that you now have a prescription in your hand, complete with generic name, and instruction to label the drug bottle, shop around for the cheapest price. Never get a prescription filled without first asking the price. Several studies have shown that this often results in a lower price. Ask the pharmacist if he prices on a wholesale cost and dispensing fee (usually cheaper for expensive drugs) or prices on a wholesale cost and percentage markup (sometimes cheaper for small quantities of drugs, but usually more expensive.)

Globally, drug company advertising and promotion should be banned. In addition, drug companies should be nationalized for research to be directed towards producing products of recognized therapeutic need instead of towards products offering great profits.

In the meantime, get involved in decisions regarding your therapy and try to get your physicians' attention drawn to your welfare. It is your right as a health consumer.



Medicine:Not the Cure for All Ills

by Stephen Bezruchka

People in the Western world expect medicine to cure their ills. To what extent is medicine able to fulfill these expectations?

Most of the public does not realize that the role of medicine in monitoring health and preventing sickness is mediocre at best. Great initial strides in understanding the basic principles of nutrition, and developing effective means of vaccination were perhaps dwarfed by concomitant advances in sanitation and standard of living. Yet, the physician commands much more respect for his activities than the garbage collector or the engineer at the water purification plant. The latter two people, however, are more important in ensuring our continued health than the physician.

Body is self-healing

It is important to understand that most of the time, the body takes care of its problems in functioning. At best, the physician oversees the process and watches for complications. Often the natural healing process is actively interfered with by the physician to the detriment of the sick individual.

Various studies show that a substantial fraction of hospital admissions are for iatrogenic disease (disease caused by the physician resulting from improper treatment). The process of doing nothing, just watching, is even called a form of therapy, usually "conservative therapy" in order to suggest a positive-active approach. For example, there is hardly any evidence that anything a physician does (short of surgery) has any effect on the common stomach ulcer (or peptic ulcer.)

Although millions of dollars are spent each year on antibiotics and other remedies for the common cold, there is no conclusive evidence that the remedies provide any benefit, (with the possible exception of vitamin C), and there is considerable evidence of harmful effects. That physican and public have the nerve to call this therapy is preposterous, but many diseases are treated in such a manner.

When a person is sick, usually the body heals itself and the physician collects the fee.

Surgery: aggressive therapy

More aggressive forms of therapy for diseases include surgery. When is this form of therapy indicated? This is not clear. There are now several studies showing that the incidence of surgery per capita in North America is twice that in the United Kingdom. Yet statistics do not indicate that we are healthier than they. Perhaps the body is able to heal itself in spite of the surgery. Maybe the surgeon is being labelled the healer more often than necessary.

The aggressive point of view finds ample expression in obstetrics. Childbirth is a natural function of the human animal that has been taking place for hundreds of thousands of years. The woman delivers the child, (unless the baby is extracted artificially), yet common parlance has it that the obstetrician delivered her baby! Again medicine unjustifiably takes too much credit. Most European countries get excellent results by careful prenatal screening and a program of home deliveries for people that are supervised by midwives.

This seems to be a rather pessimistic viewpoint, especially when coming from a physician. In order to make effective use of health care facilities, people need to realize that medicine is only one of the health arts, and that its services are best used only when indicated.

Western medicine is beginning to realize that there are other approaches. Acupuncture is one such alternative that has recently been considered as possibly effective by the medical profession.

"Antibiotics anonymous"

What are some examples of positive benefits derived from medicine? Certainly it has learned to treat and cure many infectious diseases.

While many infectious diseases are curable using conservative therapy, a fact many physicians don't realize, in a substantial number of others the patient is benefited by antibiotic therapy. However, it is interesting to note that the death rate for such infectious diseases as tuberculosis, diptheria, measles, and whooping cough has been declining steadily for 100 years. This decline was evident well before most modern discoveries in medicine and microbiology, including vaccination and antibiotics, and the rate of decrease has not accelerated since these discoveries.

But in the public's and physician's eye, medicine has taken the credit for this advance. Moreover, antibiotics, one of th major parts of the physician's armamentarium for treating infectious diseases are vastly over used. Recently, a physician writing in the prestigious New England Journal of Medicine, advocated the creation of an "antibiotics anonymous" fellowship, similar to alcoholics anonymous, to help stem this form of drug abuse by physicians.

Victims of accidents and other forms of trauma are very effectively benefited by medicine. Here, the physician puts pieces back together, and supervises the rehabilitation of the unfortunate person. There is little of comparable merit that other aspects of the healing arts can offer here.

Incurable disease

Most problems with heart disease, especially those coming on in later life, of the atherosclerotic or "hardening of the arteries" variety cannot be cured. This form of health disease appears to be affecting younger and younger people and there is little evidence that current therapy significantly affects mortality. However, life can often be prolonged, and much of this extra time is useful life.

It appears that we have the means to retard much of the early development of this disease, but there do not appear to be the appropriate economic incentives to do this. Various food lobbies, the tobacco industry, and our hectic lifestyle devoid of real physical exercise prevent us from attacking this number one health problem at its source.

High blood pressure is a disease for which we have good drug therapy that doesn't cure, but will prolong life and delay serious consequences. However, most people with this common disease are not adequately treated. Social considerations, poor health care delivery, and physician ignorance are to blame.

Cander, the number two scourge, is not now amenable to cure for the most part. Efficient, effective means of early diagnosis in the general population are not at hand. Even those that exist, like the Pap test for cervical cancer, are under-utilized probably because of lack of public information.

For political reasons again, little effort is being paid to prevention, compared to that for treating established disease, since prevention might entail drastic economic changes and similar changes in lifestyle that go against established capitalistic traditions. The two commonest cancers causing death in North America, namely those affecting lung and colon, could be drastically reduced by changing smoking habits and dietary patterns.

That knowledge of the cause and cure of cancer is just around the corner is considered unlikely by most experts. But the ability to palliate the sufferer, and to allow him or her to die relatively free of pain are important contributions made by medicine. Life can be prolonged by many current modes of therapy, and a cure is achieved in some instances. However, even with recent medical advances, it appears that the death rate for many common cancers has not changed appreciably during the last 40 years.

Diagnosis and evaluation

Much effort in hospital and medical centres is devoted towards diagnosis and evaluation. The patient feels tha this investigation is directly related to his welfare. Yet this is often not so, and the procedure is merely an academic exercise, at great expense. In most non-systems of health care delivery, in which there is payment at point of delivery of services, the patient pays for this often unncessary cost. Honest physicians will admit that it is not unusual for patients to not be significantly benefited by a hospital stay.

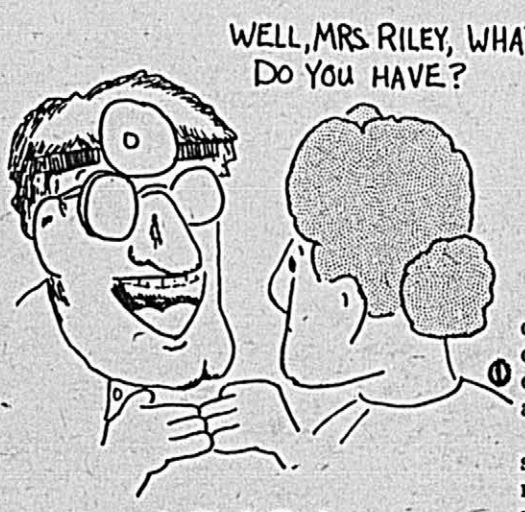
Inform people!

Most people cannot abandon medicine and probably they shouldn't. What is to be done? One needs to be able to critically evaluate medical aspects of health care and to decide where they are applicable.

Physicians and other workers of the health care industry must come down from their pedestals and realize that their position is one of helping provide one facet of a range of services. The general public must be taken into confidence and given the facts regarding illness and what role various investigations and therapies have in the final outcome. Then they can make informed decisions.

The next time you are in a doctor's office and he or she is ready to have you embark on a diagnostic or therapeutic regimen, ask what relevance this has to your well being. If you don't follow his or her advice will you compromise you health? What evidence is there to back up the statements made? If you do follow the advice, what benefits will you gain, and what complications or side effects might you incur? Giving critical information to people is the beginning of providing people with the proper perspective to approach their health problems.

Stephen Bezruchka is a graduate of Stanford Medical School and an intern at Royal Victoria Hospital.



Greed above Dedication in the Medical Profession

by Martin Shapiro

In analysing the position of the medical profession in our society, it is important not to regard it as a monolith. It is possible to discern three broad categories of physicians, each of which is worthy of independent critical analysis.

Private practitioners

The first group, comprising the majority of physicians, is composed of private practitioners. They are businessmen who render a service for which they charge a fee. The sum of all such fees collected during the course of a year is, on the average, eight to 10 times the income of the average Canadian worker, and several hundred times that of the average worker in some Third World nations.

Private practitioners reap many dividends besides their incomes. In the economic sphere, these include tax-deductible vacations, tax-deductible automobiles, even tax-deductible homes, income from investments made in the names of the other members of the family, salaries paid to family members for office work, and so on. In other areas, these physicians are, for the most part, highly respected by their patients and by the community at large for the valuable service they perform.

How valuable is this service? Some physicians in private practice are, indeed, highly competent, and very conscientious. Some are quite conscientious in their work, but embarrassingly behind the times in terms of practical and theoretical medical knowledge. Still others are lazy and incompetent. All three types of practitioners do share one characteristic: they make lots of money.

No quality control

There is no quality control in medicine. A medical act is a secret affair between physician and patient, and the patient rarely has any way of knowing whether a treatment was adequately thorough, or sufficiently indicated, or a decision based on accurate knowledge.It is the business of the private practitioner to make his patients believe in him, so the practitioner puts on a good show and is able to overcome any diagnostic or therapeutic inadequacies with slick public relations.

The conscientiousness of the physician is determined by the pre-eminence either of greed or of dedication.

Physicians are paid for each vaguely defined medical act (visit, examination, etc.), and, as we shall see, there is considerable incentive not to be conscientious. The more the patients are processed and the more patients that can be seen, the more money the physician earns. Cursory examination of the heart pays as well as detailed auscultation. Tapping on the knees brings as much into the coffers as a complete neurologic examination. Writing a prescription for a tranquilizer occupies less time than an inquiry into the causes of anxiety and so on.

On the other side of the ledger, there is little incentive to be dedicated, thorough, and complete. Other than the increased gratification of a patient, and the qualming of a conscience (if there is one), the incentives to do a good job are hard to identify. Economic considerations certainly discourage such activity.

A friend of mine recently visited a chest specialist (on consultation, because of a respiratory tract infection). The fee for the visit was $23. The visit lasted three minutes, during which time the patient's temperature and blood pressure were taken, and he was told he was well. The physician did not even bother to examine the chest, (except perhaps by observing it through street clothes). It is hard to see how such a fee was justified, but there was no way of obliging the specialist to be more thorough.

Fee-for-service means self-interested doctors

Private medical practice is a piece-work enterprise. This approach to the healing arts affects the practitioner's competence as well as his or her thoroughness. Just as it is an incentive to be less conscientious, private practice is also an incentive to be less competent.

Medical knowledge is evolving at a spectacular speed; anyone who does not devote several hours a week to reading journals, and attending lectures and conferences, is not going to be able to keep up.

No one pays the physician for the time spent updating his or her knowledge. No one is around to check up on the competence of his or her practice. No one obliges the physician to be periodically relicenced.

Time spent at these essential tasks is time away from piece-work.

Physicians are not inherently greedier than other people—not much, anyway. Like most members of the bourgeoisie, they see themselves as having a job (they are move self-serving than most about the value of their labour). They have a home in the suburbs, a cottage up North, a car or two or three, a membership in a country club. If they gave up even one tenth of their working time to the reading and updating of their knowledge, they would have to sacrifice some part of their standard of living. Few are prepared to make such sacrifices merely to feel that they are doing a better job.

Few are prepared, one might say, to resist the temptation to drift into incompetence and laziness, especially when the economic incentives all point that way. This shouldn't surprise anyone. As long as fee-for-service medical practice exists, we can hardly expect physicians to act in any but their own interests, even when these don't happen to coincide with those of the patients.

A personal anecdote might be of interest at this point. While a medical student, I had occasion to visit a private practitioner whom I had visited a couple of years previously. When I arrived, the receptionist told me that I owed four dollars to the physician including a one dollar "penalty fee" for having missed my last appointment. I asked to pay later. She pointed out that it is the doctor's policy not to see a patient who owes money. I protested that I was sick. When finally shown in to his office, I began to describe my symptoms. The physician did not look up from a file card.

He said, "I understand you are a medical student. That is the only reason I will see you today."

I do not allege that all private practitioners are this way. Enough of them are, however, to make the problem considerable.

"People" docs

The second group of physicians considered are those on salary in university hospitals. They can be categorized as either "people docs" or "dog docs". These physicians are generally much more up to dat in their knowledge than are the private practitioners. Paradoxically, they also earn a great deal less. (The average specialist in internal medicine at a McGill hospital earns between $28,000 and $40,000.) Being salaried they are able to spend more time with their patients and spend considerable time "keeping up" without suffering any additional economic hardships. Indeed, as teachers, it is part of their work to keep up to date, and pass the new knowledge on to their students.

It is not pure altruism which sends a man or woman to work in a hospital for less than he or she could earn elsewhere. Teaching students, interns, and residents does have its rewards, but there is much more than this to be gained from working in a university environment. Research can bring fame, or at least respect, far beyond one's immediate environs.

It is a major problem for many high-powered medical centres to get their "dog docs" on the ward teaching when they would rather spend their time preparing submissions to medical journals—careers coming before consciences once again.

Another problem with academic physicians is that they develop special interests. One follows patients with Cushing's Disease. Another devotes her time to systemic lupus erythematosis. And still another can find excitement only in metabolic bone disease.

While the private practitioner often fraudulently claims to be serving the community, the university physician fails the community without ever making such a claim. What the people doc does is essential, and were the community being adequately served by the health professions, one might not need to criticize the academic for failing to fulfill his or her responsibility.

Community doctors

The third group of physicians are those who work in community clinics. Within this group are two sub-groups: those who work in clinics run by the community they are supposed to serve, and those run by physicians and their ruling class allies.

Despite the protestations of the medical lobbies in Quebec, the government's concept of community clinics will leave the power in the hands of physicians. Those who work in these clinics will undoubtedly be very well paid. They will continue to practice more or less as they please. There will be no one around to criticize their work, and they will have no particular incentive to do a good job. They will not, however, have the incentives to do a bad job which privat practitioners now enjoy.

Doctors working under citizen control tend to be paid somewhat less than other groups of physicians—the proceeds from their work is fed back into other activities of the clinic.

There is some opportunity for a change in their relationship with their patients, but most continue to impose medical care from a pedestal, an approach to which both patient and physician are accustomed. There is more opportunity to review the competence of the physician, but he is often overworked, (most community clinics are under-staffed), and does not have time to "keep up". In addition, he or she lacks the contact with specialists who could facilitate the process of renewing knowledge.

Ultimately, he does a much more humane job, a less careless job, but not necessarily an ideal job, when compared with most other practitioners. Furthermore, community clinics usually provide a traditional medical environment. The idealist will soon be frustrated in his or her desire to effect change when the problems of physicians relating to patients in an office cloud his or her vision of what could be.

There is, for example, no serious effort underway in Quebec to break up the model of the physician-patient relationship and introduce nurse-practitioners and others into meaningful service roles.

The medical profession, then, is not a monolith. Almost all physicians have very comfortable livelihoods and positions in their respective communities. Almost all of them are failing their communities in one way or another. Hence, few deserve the unqualified adulation they now enjoy.

They should be seriously questioned about the extent to which they fulfill their social obligations. The excesses and failings of the private practitioners are the greatest of all, however, and breaking up the distasteful notion of profiting from another's illness should be a priority as we begin efforts to place all physicians on reasonable (that means lower) salaries.

Martin Shapiro is a graduate of McGill Medical School and an intern at the Royal Victoria Hospital.

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McGill Students' Society Logo contest. Submit designs to Students' Council offices by 4:00 p.m. Tuesday 26 March. Small cash prize. For info call: 392-8922.

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continued on page 16

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Speaking on "Chile after the coup."
McGill Student Union Ballroom
Tuesday March 19 at 8 p.m.

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New forms of struggle needed, says Brown

by Arnold Bennett

American workers are increasingly coming to regard both the state and the corporations as exploiters, according to Bruce Brown, editor of Liberation magazine, speaking yesterday in the Union.

"Just at the time when the anti-authoritarian movement seems to have subsided in the universities," he said, "we find exactly the same type of anti-authoritarian attitudes emerging among young workers in the factories."

But at the same time, because of early socialization, the capacity of workers for autonomous action is still restricted, Brown said.

"Because of Watergate the majority of Americans are aware not only of the corruption of the system but of its class nature," he said, referring to a recent poll that shows that the large majority of Americans believe that the state is run in the interests of the wealthy. "But because of their upbringing they feel incapable of organizing against this."

Brown proposed that instead of pushing for individualist wage demands, people should organize around "collective needs," like public housing and transportation or the democratization of the media. "From demands like these a real critique of the system can develop," he said.

Brown also warned that it is "no longer possible to define a socialism as state control of production and centralization planning. Socialism must mean the development of people's capacity for self-organization and for democratic control in the workplace and in the community, that will make the state superfluous."

Under this strategy of "dual power," people develop at the base of the old society "the new forms of democratic control that will characterize the new society," simultaneous with "their ultimate struggle to destroy the bourgeois state," he said.

One of the major achievements of such grass-roots struggles is that workers can develop their capacity to act and can overcome the constraints of their social conditioning, Brown explained.

"But it's a long process. One can't simply abolish the authoritarian personality by advancing slogans about cultural revolution, like the New Left did."

today

Films from China:
"Sha Shi Yu (A commune)", "Ta Ching (an oil field)", "Cultural Relics Unearthed During the Cultural Revolution" and "Martial Arts", 8 p.m. FDA. Free admission.

Workers Support Committee:
Regular meeting tonight at 6 p.m. in Union 307 Educational on Quebec Labour:— Immigrant Labour, speakers from Mouvement Progressiste Italo-Quebecois (MPIQ) and le Comite pour la Defense des Droits des Travailleurs Haitiens (CDDTH) Union 307 #:15 p.m.

Graduate English Colloquium:
Professor Donald Theall speaks on James Joyce. Arts Council room. All welcome. See notice on door.

MSSA Talk:
Professor Gutkind of Dept. of Anthropology speaks on "Urbanizaiton and Development Problems in the Third World." 7 p.m. Union 327.

Swedish Ambassador to Chile:
Harald Edelstam, expelled from Chile by the military Junta, will speak on his experiences and conditions in Chile after the coup. 8 p.m. Union ballroom.

Cheerleaders:
Attention girls! Do you want to be a cheerleader for the McGill Redmen Football team for Fall 74? If so come to the try-outs in the Curry Gym at 5 p.m. in the foyer. We need your support.

Film Series:
Jane Fonda, and Michael Sarrizin star in "They Shoot Horses Don't They?" 4 p.m. in Palmer Howard Theatre (McIntrye 522). 50 cents.

Yellow Door:
Hot lunch! All you can eat 45 cents. 12-2 p.m., 3625 Alymer.

Christian Fellowship:
Everyone welcome to today's meeting on "Dating: The Old-fashioned Game?" Ramez and Becky Attalah will be answering your questions! 1-2 p.m. in Union 457.

Committee for More Student Housing:
Anyone interested in the results of the surveys which the committee has conducted of student housing facilities around the university can attend plans for further action to be discussed. Union 123 at 1 p.m.

what's what

FARMWORKERS' SUPPORT COMMITTEE
Meeting tomorrow, 6-7 p.m. in Union 123-124.

SANDWICH THEATRE
Auditions for "The Dock Brief" by John Mortimer are being held today and tomorrow from 4-6:30 p.m. in Union 327. The show will open April 16; only male actors are needed. Newcomers welcome. If you can't make these times phone 392-8989 for an appointment.

POETRY READING
Artie Gold, one of the "4 Montreal Poets" by Fiddlehead Press, reads at 477 Milton at 1 p.m. on Thursday, March 21.

MALAYSIAN-SINGAPORE STUDENTS
Don't forget AGM tomorrow in Union 307 at 7 p.m. Voice your questions, complaints and encouragements. Elect your committee for 74-75. Tim-Sum and tea.

PRE-MED SOCIETY
We would like to thank all members for their patronage and announce the remaining films for the term: "The World of the Schizophrenic" and "The Dynamics of Alcoholism" on March 21, "Hospital Sepsis" on March 28, "Tracheotomy and Cricothyrotomy" and "An Effective Treatment of Burns" on April 4 and "Safe Cerebro Electrotherapy" on April 11. All films are at 1 p.m. in the Martin Lecture Theatre (6th floor McIntyre).

RESIDENCE HARPSICHORD
Tomorrow at 8 p.m. in McConnell Residence, Robert Sigmund will give a lecture demonstration and harpsicord recital. All welcome.

ARAB STUDENTS' SOCIETY
Interested in joining our party on Saturday, March 23? Come to the coffee lounge, first floor Union. There are still some tickets left and they will be sold at the door starting from 6 p.m. All welcome.

YOUNG ALUMNI
"A Dialogue with Donald MacDonald", tomorrow in Leacock 821 at 8 p.m. Admission by ticket only, available at 3605 Mountain Street.

POLITICAL SCIENCE TAA
Meeting of the Political Science TAA, tomorrow at 7 p.m. Same room as last week.

ISA ELECTIONS
The International Students' Association will hold its elections for the positions of President, Vice-President, Executive Secretary, Treasurer, and Public Relations' Officer for the '74-'75 term on Wed. April 3rd. Nominations are open to all students. Each candidate will need 5 nominations from the ISA Council (ISA executives and National Club leaders). Closing date for nomination is Tuesday, April 2nd. Please forward all forms to Chief Returning Officer, Michael McCatty in the ISA Office, Union B-40.

EXHIBITIONISM IN McLENNAN LIBRARY
During the past few months there have been a number of incidents of sexual exhibitionism in McLennan Library (and we don't mean streaking). Most often this has involved men masturbating in front of women who are studying alone. This has happened to seven women that we know of, and probably others as well.

It is difficult to initiate action against these offenders as they always seek out situations where there can be no witnesses and therefore no recourse can be taken. Individually these women are powerless, as there is little that can be done if there are no witnesses. However, we believe that a collective effort can effect change.

It is evident that the onus is upon the women who are concerned with combating the situation to do something about it. A plan of action is being considered. All concerned—especially those women who study regularly in McLennan in the evenings—are urged to attend a meeting Tuesday, March 19th at 1 p.m.—room to be announced: call DAILY office for info.

CENTRE FOR DEVELOPING AREA STUDIES
Workshop No. 17 — Friday, March 22nd at 12:15 p.m. at the Centre, 3437 Peel Street, 2nd floor, lounge—refreshments will be served. Subject: Guyanese Americians—resources and livelihood—problems of the near future (we hope a new film of it arrives on time). Speaker: Mr. D. Cook (geography graduate student) and/or professor T.L. Hills.

CHILE SOLIDARITY
Petitions are being circulated during this week all over campus demanding an end to the repression and a restoration of civil liberties in Chile, and requesting the Canadian government to withhold aid from the Chilean military junta and grant political asylum to victims of the coup. Please sign one if it comes your way. For further information, or if you wish to help with this campaign, leave a message for Chile Solidarity at the Daily office (392-8956).

ASUS FILMS
The ASUS Film Series will be showing one of the best made films of the past five years, "They Shoot Horses Don't They?" on Tuesday, March 19th at 4 p.m. in the Palmer Howard Theatre (McIntyre 522). Admission is only 50 cents.

SCM
The Student Christian Movement is presenting a Mini-Folk Music Festival on Saturday, March 23rd in Redpath Hall. From 2 to 6 p.m. workshops demonstrating instruments and styles of folk music. Los Guinchimali will headline the evening concert (8-12 p.m.). Advance tickets $2.50, on sale at Yellow Door.

THEATRE
"Monologue and Death" by Emily DeWolfe with Sharry Flett. Wednesday, March 20th and Friday, March 22nd at 12 noon in the Education building room 129, 3700 McTavish.

ANTHROPOLOGY LECTURE
Professor Marvin Harris of Columbia University will give a lecture in the "Future of Anthropology Series," entitled: "CM = CE + HM," on Thursday, March 21st at 4 p.m. in the Leacock council room, L-820.

PROGRESSIVE URBAN MOVEMENT
Interested in Montreal's Urban Problems? Want to work towards a new conception of urban politics based on the needs and ~~wants~~ of citizens rather than on the private profits or corporations? The Progressive Urban Movement invites the McGill community to participate in the growing opposition to the politics of the Drapeau administration. If interested, please call Linda Bass, evenings at 845-6620.

COMMUNITY McGILL
Douglas Hospital urgently needs people to tutor a middle-aged man in basic reading and writing skills.

Male volunteer needed to accompany 13 year old boy from school to learning centre (downtown area) on Monday afternoons. For further information call 392-8980 or come to Union 416, 12—2 daily.

THROW OUT THE LIBERALS
We call on students to join the Young Socialists' campaign for jobs, to turn to the strength of the working class in the fight to bring down the Trudeau government. March on St. Denis Street, Saturday, April 6th at Laurier East and Mentana, dinner and party after. Come to the YS meetings on Wednesday at 1 p.m. in the Union to organize the campaign.

SAVE MONTREAL— FROM WHAT?
Panel discussion Monday, March 25th at 8 p.m. at Sir George Williams, Hall Building, H-110. Aim: to promote public awareness of progressive planning. Panelists: John Parker, Montreal City Councillor; Joe Baker, Progressive Urban Movement and John Richmond, literary editor, Montreal Star, Moderator, and others. Free admission.

MOC BANQUET
Our Annual banquet with roast chicken dinner and sentimental slide show. Everyone is welcome. On Friday, March 29th at 7 p.m. at the William Tell. Tickets are $3.00, available at Union box office starting Monday, March 25th.

WORKERS' SUPPORT COMMITTEE
Regular meeting Tuesday, 6 p.m., room 307. Educational on Quebec labour: this week immigrant labour speakers from Mouvement Progressif Italois-Quebecois and Le Comite Pour la Defense des Droits des Travailleurs Christiens Haitiens, room 307 at 7:15 p.m.

ENGLISH DEPARTMENT
Presents Richard Ellmann speaking on "Ulysses as Epic," March 21st, in L-219 at 8 p.m.

MALAYSIAN-SINGAPORE STUDENTS' ASSOCIATION
Professor Gutkind of the department of anthropology, will speak on urbanization and development problems in the Third World, Tuesday, March 19th, 7 p.m. in Union room 327.

SWEDISH AMBASSADOR TO CHILE
Harald Edelstam, expelled from Chile for helping refugees and victims of the repression, and senior member of the Swedish Diplomatic Corps will be speaking at McGill on the repression in Chile, Tuesday, March 19th, Union ballroom, 8 p.m.

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what's what

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BRIDGE CLUB

1st annual duplicate bridge game, March 19th. At this game we will discuss future plans for the club, so everyone must attend. Union 123-4, 6:45 sharp.

POLITICAL SCIENCE ASSOCIATION

Political Science Association wants all members at the open meeting this Wednesday, March 20th at 4 p.m. in L-111. The purpose is to discuss the future of this association. All students of political science are urged to attend.

WORLD UNIVERSITY SERVICE OF CANADA

With the co-operation of the faculty of music, WUSC at McGill is sponsoring a Jazz Workshop, Wednesday March 20th, 8:30 p.m. in Redpath Hall. Three bands will be playing contemporary arrangements in what promises to be a lively evening. Proceeds are to go towards installing pumps in 3 villages in Mysore, India. Tickets at Union box office. Advance $1; at door, $1.50.

ISA

The International Students' Association is sponsoring an International Festival from March 21st to March 23rd. A cultural evening with multi-national songs and dances will be held Thursday, March 21st at Douglas Hall, 3851 University Street, 8 p.m. There will be films and lectures on Third World-dependence and development, Friday, March 22nd at 12 noon and 8 p.m. in the Union. Information and tickets will be available through the ISA office, B-40 in the Union.

CHINESE CULTURAL FESTIVAL

March 19th: Films from China: The Red Banner of Ta Ch'ing; Cultural Relics Unearthed During the Cultural Revolution; ShaShi-Yu; Martial Arts. Frank Dawson Adams Auditorium, 8 p.m. Admission free.

March 20th: One Quarter of Humanity, a documentary classic by Edgar Snow; Frank Dawson Adams Auditorium, 8 p.m., 10 p.m. Admission, $1.50.

March 23rd: Cantonese Debating Tournament: preliminaries. 2 p.m. in L-26.

classifieds

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HOUSING

Apartment to sublet. May 1 to Sept. 1, 4½ large rooms, $150. Furnished or not. 845-3657.

SUBLET, Large, clean 4½, near McGill, available from May, lease renewable, rent negotiable, call 845-5650.

One or two people to share downtown apartment (Bishop Street) with another peachy person. May — August. Furnished, own rooms. Phone 849-1508.

SPACE to let. For workshop or club $225 (heating included). Furniture, T.V. and sound system for sale. Tel: 845-5879.

MISCELLANEOUS

Honesty, trust, sensitivity talk — 4th floor. Union Bldg. #409, Interaction McGill 392-8981.

STREAKERS AND VOYEURS — Spring time romp is Tuesday at high noon. See Eval Kaneval streak on a motorcycle. Squaws burn those bras. Jocks show them rocks.

Free-Affectionate part Persian Female tabby. 2 years — to good home. 933-6283.

Studio art courses for credits. Pre-summer course in print-making. May 13 - May 31. Various other summer courses. July 2 — August 9. 392-8858, 392-8855.

STREAKER — Today, Tueusday's, the day. Follow the naked path, from main floor Leacock to Administration Building to McConnell Engineering to Neuroddick gates to Maclennan Library 6th floor at high noon. Have a ball!

To Roz, — days — of a nation —s of our lives, from Unowho.

2 black kittens (10 weeks) one male, one female need home (no charge). Jocelyne day 392-3027. Night 738-[illegible]84.

S.O.C. BANQUET. Our annual banquet will be held this year at the William Tell on Stanley St., Friday March 29 at 7:00 p.m. Tickets available at Union Box office for $3.00 starting Monday, March 25. Everyone is welcome. Reminiscing slide show as well.

ENTERTAINMENT

Wednesday MFS presents IF and STRAWBERRY STATEMENT. If you like strawberries be sure to bring some along to Leacock 132 at 7:30. 75 cents (cheapo) will get you and your berries into both flix.

Premier Concerts presents

MURRAY McLAUCHLAN in concert

FRIDAY, APRIL 12th at 8:00 P.M.

Tickets $3.00, $4.00, $5.00

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